Meeting: **Health and Wellbeing Board**

Date/Time: **Thursday, 29 May 2025 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Euan Walters (Tel: 0116 305 6016)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Mr. M. Squires CC (Chairman)

Barney Thorne	Jean Knight
Edd de Coverly	Rachel Dewar
Harsha Kotecha	Simon Pizzey
Jane Moore	Kevin Allen-Khimani
Mike Sandys	Fiona Barber
Jon Wilson	Siobhan Peters
John Sinnott	Mr. C. Pugsley CC
Rachna Vyas	Mr. J. Boam CC

AGENDA

Item		Report by
1.	Appointment of Chairman. To note that the County Council's Lead Member for Health, Mr. M. Squires CC, has been appointed Chairman.	
2.	Minutes of the meeting held on 27 February 2025.	(Pages 3 - 12)
3.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	
4.	Declarations of interest in respect of items on the agenda.	

5.	Position Statement by the Chairman.		
6.	NHS Transformation.	Integrated Care Board	(Pages 13 - 38)
7.	Neighbourhood Health Programme.	Integrated Care Board	(Pages 39 - 48)
8.	Resilience Strategy.	Integrated Care Board	(Pages 49 - 68)
9.	Pharmaceutical Needs Assessment	Director of Public Health	(Pages 69 - 176)
10.	Adults and Communities Strategy.	Director of Adults and Communities	(Pages 177 - 214)
11.	HWB Development Sessions evaluation.	Director of Public Health	(Pages 215 - 222)
12.	Better Care Fund - year end 2024-25.	Director of Adults and Communities	(Pages 223 - 256)
13.	Better Care Fund Plan 2025-26.	Director of Adults and Communities	(Pages 257 - 402)
14.	Joint Health and Wellbeing Strategy progress update on Living and Supported Well and dying well.	Director of Adults and Communities	(Pages 403 - 416)
15.	Joint Health and Wellbeing Strategy progress update on Staying Healthy, Safe and Well.	Director of Public Health	(Pages 417 - 432)

16. Date of next meeting.

    The next meeting of the Health and Wellbeing Board will be held on Thursday 25 September 2025 at 2.00pm.

17. Any other items which the Chairman has decided to take as urgent.

Agenda Item 2

Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Thursday, 27 February 2025.

PRESENT

Leicestershire County Council

Mrs L. Richardson CC (in the Chair)
Mrs. C. M. Radford CC
Mike Sandys
Jon Wilson

Integrated Care Board

Rachel Dewar

University Hospitals of Leicester NHS Trust

Simon Pizzey

Leicestershire Partnership NHS Trust

Jean Knight

District Councils

Edd de Coverly

Healthwatch Leicester and Leicestershire

Fiona Barber

Voluntary Action Leicestershire

Kevin Allen-Khimani

In attendance

Cheryl Bosworth (minute 53 refers)
Tracy Ward (minute 53 refers)
Ben Smith (minute 54 refers)
Kate Revell (minute 54 refers)
Mala Razak (minute 55 refers)
Joshna Mavji (minute 56 refers)
Abbe Vaughan (minute 56 refers)
Lisa Carter (minutes 57 and 58 refer)

Apologies

Mrs. D. Taylor CC, Dr Nikhil Mahatma, Cllr Cheryl Cashmore, Jane Moore and Siobhan Peters.

49. Minutes of the previous meeting.

The minutes of the meeting held on 5 December 2024 were taken as read, confirmed and signed.

50. Urgent items.

There were no urgent items for consideration.

51. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

No declarations were made.

52. Position Statement by the Chairman.

The Chairman presented a Position Statement on the following matters:

i) Adult Social Care;
ii) NHS;
iii) End of Life Strategy update;
iv) Health & Wellbeing Board Development Session;
v) Community Engagement Activities;
vi) Key messages.

A copy of the position statement is filed with these minutes.

RESOLVED:

That the position statement be noted.

53. Integrated Personalised Care Framework.

The Board considered a report of the Director of Adults and Communities which provided an update on progress in relation to the Framework for Integrated Personalised Care (FIPC) and redesign of the training model which underpinned it. A copy of the report, marked 'Agenda Item 5', is filed with these minutes.

Arising from presentation of the report the following points were noted:

(i) Where tasks were delegated from health to social care, clinical oversight would be maintained by the delegating organisation. Concerns were raised about whether the clinical governance and oversight would be sufficient in some cases, particularly where patients were discharged from acute hospitals and GP Practices then took over responsibility for that patient. In response reassurance was given that full training would take place before the patient was discharged, and the patient would receive the same support with medication that anybody else registered with a GP

would receive. In addition, shared care records and handover procedures would make it clear what the patient required and which tasks were delegated. Nevertheless, it was agreed that further conversations would take place with Primary Care to ensure that they knew their responsibilities.

(ii) Concerns were also raised that the decision of the Integrated Care Board to cease Shared Care funding could have an impact on the County Council with regards to delegated tasks which the County Council did not recharge the NHS for. In response it was explained that all individuals currently in receipt of the service would be reviewed and consideration could be given to whether their care was jointly funded. An impact assessment had been carried out with regards to the effect of this change on patients, but the full impact would not be known until cases were reviewed and it could be established which pathway patients needed to be placed on.

(iii) In response to a question as to how patients and carers would be able to feedback their experiences in order to influence training programmes, it was confirmed that conversations with patients and family members would take place.

(iv) According to the timetable the procurement plan for specialist delegated healthcare tasks would be completed by March 2026. In response to a query about training in the intervening period, reassurance was given that the current training module would continue, and a record was always kept of which organisations attended the training. However, organisations did not have to accept the delegation of healthcare tasks if they did not feel that sufficient training had been provided.

RESOLVED:

That the update on progress in relation to the Framework for Integrated Personalised Care and redesign of the training model be noted.

54. Leicester, Leicestershire and Rutland Dementia Strategy 2024-28.

The Board considered a report of the Director of Adults and Communities which regarded the 2024-28 Leicester, Leicestershire and Rutland (LLR) Dementia Strategy and provided an update on the development of the Leicestershire Dementia Strategy Delivery Subgroup. A copy of the report, marked 'Agenda Item 6', is filed with these minutes.

Arising from discussions the following points were noted:

(i) There was a disparity in the dementia diagnosis rates across LLR in that for Leicester 77.5% of people living with dementia had received a diagnosis whereas for West Leicestershire it was 61.8% and for East Leicestershire 60.8%. The diagnosis rate for Rutland was 54.8%. This trend was reflected nationally where cities had a higher diagnosis rate than rural county areas. It therefore appeared that economic factors and deprivation were not a relevant factor for dementia diagnosis. Instead, other factors were believed to be more relevant such as isolation which meant people were better able to hide the signs of dementia from others. It was queried whether GPs were being sufficiently proactive to identify patients with dementia. It was also noted that the memory assessment service ran by LPT was based in the city centre which could have an impact on the types of people that attended for appointments. Satellite dementia clinics had now been implemented in

the county, and this could have a positive impact on dementia diagnosis rates in people from rural areas. The introduction of Neighbourhood teams would also help the identification and referral process.

(ii) Referral to the memory assessment service took time and the average waiting time was 16 weeks. It was expected that the recent withdrawal of funding from the service would result in increased waiting times. However, the Board was pleased to note that whereas previously the dementia support service would liaise with a patient once the diagnosis had been made, it was now involved as soon as the referral was made and Age UK could also work with the patient straightaway.

(iii) It was important to make every contact count and housing teams at district councils could play a role in identifying people that may be suffering from dementia. District health leads could also play a role.

(iv) Thanks were given to Healthwatch Leicester and Leicestershire for their help with the engagement work. The number and quality of responses was pleasing. It was felt that Healthwatch were able to get better responses than if the County Council had carried out the consultation directly. Engagement had taken place with hard to reach groups in both the city and the county. More engagement was required with rural and farming communities.

(v) It was suggested that the strategy and engagement work should include reaching out to those people that were excluded from accessing digital methods of communication.

(vi) Voluntary Action Leicestershire requested to be involved with the dementia awareness raising activities given the contacts they had with a large number of organisations.

(vii) In response to a question, reassurance was given that links would be made between the Dementia Strategy work and Active Together, and a Public Health representative sat on the Dementia Programme Board who would be able to act as a conduit.

(viii) It was queried whether the dementia work did in fact have an equalities impact and suggested that future reports to the Board could have the Equality Impact Assessment appended to it to enable Board members to understand the equality implications.

(ix) It was queried how successful the previous dementia strategies had been and how it could be ascertained whether the current strategy was having a positive impact and what success looked like. In response it was explained that assurance would be provided through regular updates to the Health and Wellbeing Board.

(x) There was a shortage of care homes for people with dementia. This was significant because it often became increasingly difficult for families to deal with dementia patients as their condition progressed.

(xi) The loneliness of the carers of people with dementia needed to be addressed.

RESOLVED:

(a) That the information provided on the 2024-28 LLR Dementia Strategy and the consultation that informed the development of the strategy be noted;

(b) That the information provided on the development of a Leicestershire Dementia Strategy Delivery Subgroup and Action Plan be noted.

55. Joint Health and Wellbeing Strategy progress update on Best Start For Life.

The Board considered a report of the Children and Family Partnership which gave an update on progress in relation to the Best Start for Life priority of the Joint Health and Wellbeing Strategy (JHWS) 2022-32. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

Arising from discussions the following points were noted:

(i) The Children and Families Strategy was being reviewed at the same time as the Health and Wellbeing Board strategy and the two pieces of work were being linked and communication was taking place between officers involved in both strategies.

(ii) In December 2024 the Department for Education had announced continued funding for Family Hubs in Leicestershire for 2025-26. The Chair expressed disappointment that it had only been extended for one year.

(iii) It was queried whether work took place with mothers in the period after conception and before birth and suggested Family Hubs could cover this. It was agreed that this would be checked and an answer provided after the meeting.

(iv) When Children in Care reached the age of 18 they were referred onto Adult Care Services, however some of them still needed the type of services provided by Child and Adolescent Mental Health Services (CAMHS). So far there had been difficulties in finding an equivalent service for these people once they turned 18. The Looked After Children's Health Team run by Leicestershire Partnership NHS Trust (LPT) supported people up until the age of 25, and adult mental health teams were also available, so there should be services available for care leavers. LPT agreed to liaise with Children and Family Services about this.

(v) Whilst people were waiting for mental health services they could use the tellmi mobile phone app and the Chat Health website. The information was also shared in schools.

(vi) Data showed that single mothers aged 21 or below in LLR attended the Emergency Department at least once a year for a condition that did not require any treatment. It was questioned whether the Emergency Department was the most appropriate place to take these children and whether the strategy could give consideration to alternative venues for these mothers to receive the help they required. It was agreed that discussions about this would take place after the meeting.

(vii) A national survey indicated that 1 in 3 children refused to attend education and it was queried whether this could be addressed as part of the strategy. It was agreed that discussions about this would take place after the meeting and any conclusions would be fed into the refresh of Children and Families Partnership Plan.

(viii) It was queried whether there was ongoing work within the partnership around antenatal and postnatal care, including smoking cessation and weight management, as this was a key focus from a 'place' perspective between Public Health and the Integrated Care Board. A key consideration was how to strengthen the health focus in this area without destabilizing the valuable work that the Children and Family Partnership was doing around the wider determinants of health and education.

(ix) In Melton, as part of a pilot scheme, the Family Hubs had been working closely with GP Practices to provide health advice to children. It was intended to replicate this pilot in other parts of Leicestershire. Though it was noted that Melton only had one Primary Care Network, whereas other areas had more than one which could bring greater complexity and challenges. Outcomes in other parts of the county would need to be monitored and the Integrated Care Board could link in with this work.

(x) In response to a question as to whether the impact of screen time on child development and the affect of social media on teenagers emotional wellbeing was being considered as part of the Strategy work, it was explained that some work was already taking place in this regard but further work would need to take place.

(xi) It was questioned how the success of the Strategy was measured, where the Strategy had the most positive impact and which areas needed further development. In response assurance was given that these questions would be considered, and further information would be provided after the meeting.

RESOLVED:

(a) That the progress being made in relation to delivering against the Best Start for Life priority be noted;

(b) That the progress being made in relation to delivering against the cross-cutting priorities be noted.

56. Joint Local Health & Wellbeing Strategy Review - Approach and Plan.

The Board considered a report of the Director of Public Health which provided a detailed approach and timeframe for the review of the Joint Local Health and Wellbeing Board Strategy (JLHWS). A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

Arising from discussions the following points were noted:

(i) The JLHWS review was proposed to cover the question of whether COVID-19 Recovery should still be a priority. It was suggested that this topic should be broadened out to include how prepared Leicestershire was for another pandemic. It was noted that work regarding this was taking place through the Local Resilience Forum and through the NHS, and reference could be made to that work in the JLHWS to help reassure the public that the matter was in hand. Updates could also be brought to future HWB meetings which would link in with the health protection work that the Board was already due to review.

(ii) Members welcomed the proposal to setup and launch a JLHWS Steering Group particularly as it would help identify gaps in the work. Rachel Dewar offered to be the ICB representative on the Steering Group.

(iii) Concerns were raised that the timeline was tight and it needed to be clarified quickly who was expected to be involved and what was expected of them. Some reassurance was given that the risk register covered this issue and parts of the work were ready to be launched.

(iv) It was queried whether the English Devolution White Paper published 16 December 2024 should be taken into account in the JLHWS work bearing in mind that local government structures could change as a result. It was thought more helpful to focus on system, place and locality rather than local government terminology.

RESOLVED:

(a) That the suggested approach be approved;

(b) That the detailed plan including milestones be approved;

(c) That Board members seek support/commitment from partners to input into the work;

(d) That an agile approach to governance be approved including the setup and launch of a Joint Local Health and Wellbeing Strategy (JLHWS) Steering Group;

(e) That the subgroups be asked to nominate representatives for the JLHWS Review Steering Group.

57. Better Care Fund Quarter 3 2024/25 return

The Board considered a report of the Director of Adults and Communities regarding the quarter 3, 2024/25 report of the Better Care Fund. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

With regards to Emergency Department Admissions which appeared to be on the increase it was pointed out that many of these were not genuine admissions but actually patients attending the same day emergency care service. Work was taking place to separate the data and identify how many of these were genuine admissions.

The previous report had incorrectly stated that during the first quarter of 2024-25 University Hospitals of Leicester NHS Trust experienced an increase in attendances of 30% when in fact the correct figure was 11%. This had now been corrected in the published data.

RESOLVED:

(a) That the performance against the Better Care Fund outcome metrics, and the positive progress made in transforming health and care pathways up to quarter 3 be noted;

(b) That the action taken by the Chief Executive of Leicestershire County Council, following consultation with the Chairman of the Health and Wellbeing Board, to approve the BCF Quarter 3 report and use of powers of delegation to approve this for the NHSE submission deadline of 14th February 2025, be noted.

58. Better Care Fund 2025/26 planning

The Board considered a report of the Director of Adults and Communities which provided an overview of the progress to date on the draft submission of the Leicestershire Better Care Fund (BCF) Plan 2025-26. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

As part of discussions the following points were made:

(i) There was an extremely tight timescale for this work with the submission guidance documentation only being published on the 31 January 2025, income and expenditure only finalised on 19 February 2025, and a national submission deadline of 31 March 2025. It was queried whether any opportunities had been missed due to the timescale and whether any changes would have been made to the submission if there had been more time. It was also questioned whether other areas of the country had come up with innovative ways of spending the BCF that had not been considered in Leicestershire. In response some reassurance was given that review always took place of whether the submission could have been put together in a more effective way, but the Board was reminded that the submission had to link to the BCF policy framework and suggestions had to be possible within the BCF. It was suggested that a workshop could take place in the summer to consider options for the next BCF submission. This would give Leicestershire a head start and allow Health and Wellbeing Board members to have an influence before the submission was made, though it was noted that the detailed guidance for the next submission would not be published by the summer. It was suggested that the majority of the BCF should still be focused on community and prevention.

(ii) The Integrated Care Board (ICB) minimum NHS contribution for 2025/26 was £57,070,979. Detail on the splits would be provided to Board members in due course.

(iii) Originally the uplift to the NHS minimum contribution was to be 1.7% however this had now changed and it would now remain static in return for the Discharge Grant being retained. This meant that activities which were funded by the Discharge Grant and which had been thought could no longer be funded, could now be retained. Some items which were previously funded by the ICB Discharge Grant would now be funded by the local authority Discharge Grant.

(iv) The National Conditions in the template had changed slightly from previous years. For example National Condition 2 now had the policy objective of demonstrating a 'home first' approach and a shift away from use of long-term residential and nursing home care. There was also a move away from treatment towards prevention.

(v) There was now an additional metric for average length of discharge delay for all acute adult patients.

(vi) There were now six supporting metrics but the BCF return was not dependent on them. However, work would be taking place to ensure that the work across the system aligned with the supporting metrics.

RESOLVED

(a) That the content of the report be noted;

(b) That the draft narrative document, attached as Appendix A, that details the proposed contents of the Better Care Fund Plan return, be noted;

(c) That the Chief Executive of Leicestershire County Council, following consultation with the Chairman of the Health and Wellbeing Board, be authorised to finalise the Better Care Fund Plan before the national submission deadline of 31st March 2025.

(d) That it be noted that the members of the Integration Executive, at its meeting on 4th March 2025, will be asked to indicate their support for the Better Care Fund Plan ahead of the final submission to NHS England.

59. Date of next meeting.

RESOLVED:

That the next meeting of the Board take place on Thursday 29 May 2025 at 2.00pm.

2.00 - 4.30 pm CHAIRMAN
27 February 2025

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Agenda Item 6

HEALTH AND WELLBEING BOARD: 29 MAY 2025

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

NHS TRANSFORMATION UPDATE

Purpose of report

1. The purpose of this report is to provide the Board with an update on changes to NHS structures which are taking place.

2. The aim is to make the Board aware of the of the current situation and the 'knowns' related to the transformation, including local implications.

Recommendation

3. The Board is asked to note the information provided in the report.

Background

4. The government announced during March 2025 that over the next two years, NHS England (NHSE) will be formally integrated into the Department of Health & Social Care (DHSC). The announcement also included that running costs of Integrated Care Boards (ICBs) will be reduced by around 50%. There is also an ask to all NHS providers to focus on productivity and deliver value.

5. The new Chief Executive Officer of NHSE, Jim Mackey, wrote to the NHS to share further information on the transformation plans, including the future plans for Integrated Care Boards (ICBs) which can be read in full here: https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/

6. A model for ICBs has now been shared to support executive teams to put in place next steps to support the changes – the full details are attached below.

The role of the ICB – what will it look like?

7. There are 42 ICBs across the country which are responsible for planning health services for their local population. ICBs manage the NHS budget, allocate resource, and oversee the delivery of healthcare services to improve outcomes. The Leicester, Leicestershire and Rutland Integrated Care Board is the ICB for this region.

8. The national 10 Year Health Plan sets out a leaner and simpler way of working, where every part of the NHS is clear on its purpose, what it is accountable for, and to whom. https://www.england.nhs.uk/long-term-plan/ The 10 Year Health Plan will be published later this year and will include more detail on the wider system architecture and clarify the role and accountabilities of trusts, systems, and the centre of the NHS.

9. The new model for ICBs focusses on strategic commissioning to support the delivery of the 10 year plan by:

    - Increase population health;
    - Improve access to more consistently high quality care;
    - Help deliver strategies that move more funding and support out of hospitals and into local services;
    - Reduce inequalities and work with people who use services and communities to develop strategies to improve and tackle inequalities.

10. The model asks for ICBs to cluster where necessary in order to reduce running costs by up to 50%. The aim is to reduce duplication, improve efficiencies and support collaboration between health and care organisations. ICBs will be funded based on a per-head population cost, around £18 per head, as part of the transformation.

11. These changes will mean that some work the ICB does at the moment will move to providers of services, local authorities or other parts of the NHS, subject to legislation changes.

12. To make these changes staff working in the ICB will need to be supported through a management of change, and the national timeframe for this is planned to be worked through and delivered by the end of the calendar year.

What does this mean for LLR

13. The ICB executive team is working closely with colleagues across the East Midlands to consider the next steps. Discussions so far have focused on the future ICB model, the

significant savings required based on per-head population costs, and the potential development of a cluster model as a planning assumption.

14. Details around the emerging clusters across the East Midlands are still being worked through. As these are finalised, the national team will confirm the final cluster alignments.

15. There is still a significant amount of work to do to fully understand and implement the changes needed to deliver the ambition of the national transformation plan. To support this, weekly meetings are taking place at national, regional, and local levels to ensure progress is made at pace and with alignment across the system.

What does this mean for patients?

16. The changes will not impact anyone's access to the NHS - it will still be free at the point of use and cover all the services it does already.

17. The biggest changes are about who makes decisions and who spends the money.

18. In the long term, the NHS may look different - but patients going to see their GP or going into hospital will see little visible difference.

Latest updates

19. We will continue to keep you updated through our stakeholder updates – Five for Friday. If you have any questions, please get in touch via llricb-llr.corporatecomms@nhs.net

More information

20. For more information see the following links:

BBC – What does NHS England do?

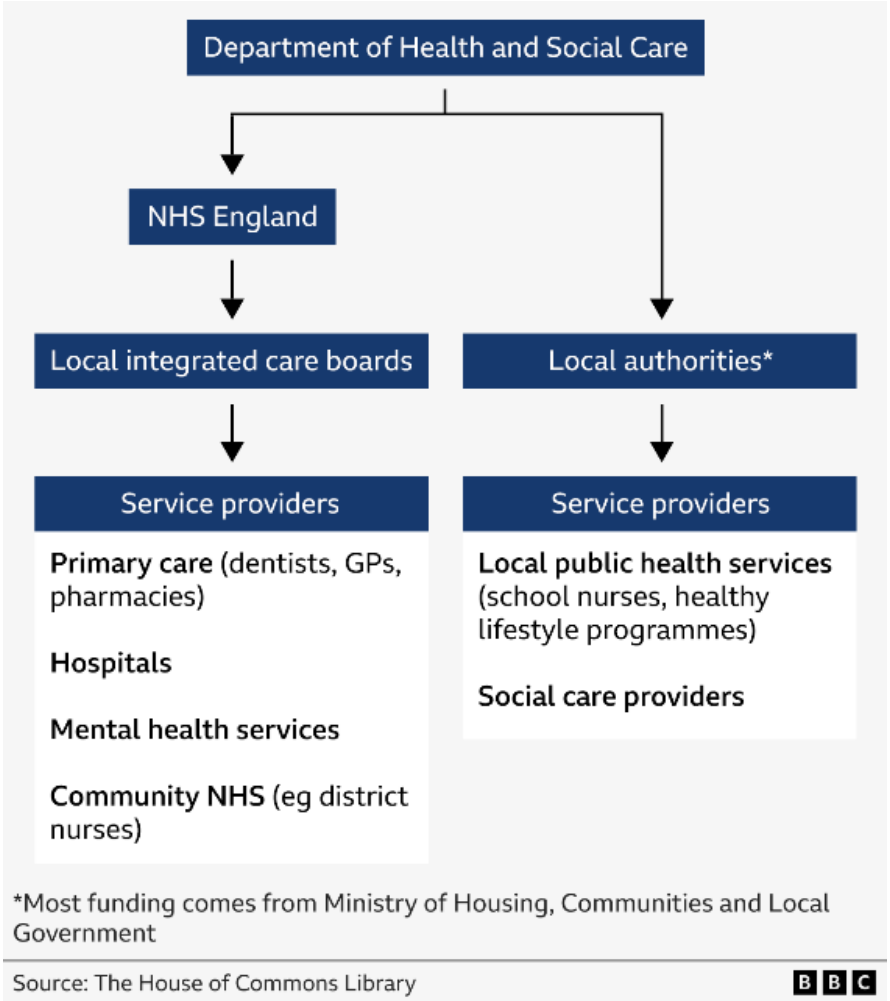
NHS Confederation – NHS Changes – all you need to know

Kings Fund – The reshaping of NHS Bodies

For more information about Leicester, Leicestershire and Rutland ICB

How the NHS is funded

21. The following diagram demonstrates the flow of funding for the NHS and health services:


Department of Health and Social Care
NHS England
Local integrated care boards
Local authorities*
Service providers
Primary care (dentists, GPs, pharmacies)
Hospitals
Mental health services
Community NHS (eg district nurses)
Service providers
Local public health services (school nurses, healthy lifestyle programmes)
Social care providers
*Most funding comes from Ministry of Housing, Communities and Local Government
Source: The House of Commons Library
BBC

Background papers

https://www.digitalhealth.net/wp-content/uploads/2025/05/Model-Integrated-Care-Board-%E2%80%93-Blueprint-v1.0.pdf

Appendices –

Appendix A - Model Integrated care blueprint

Officer to contact

Name and Job Title: Rachel Dewar

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Email:Rachel.dewar@nhs.net

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Appendix A

Model Integrated Care Board – Blueprint v1.0

Introduction

On 1 April, we wrote to Integrated Care Board (ICB) and provider leaders outlining how we will work together in 2025/26 to deliver our core priorities and lay the foundations for reform. The letter set out the critical role ICBs will play in the future as strategic commissioners, and in realising the ambitions that will be set out in the 10 Year Health Plan. As ICBs need to develop plans to reduce their costs by the end of May, we committed to clarifying the role of ICBs by co-producing a Model ICB Blueprint and sharing the functional output of this work.

This Model ICB Blueprint has been developed by a group of ICB leaders from across the country, representing all regions and from systems of varying size, demographics, maturity and performance. It is a joint leadership product, developed and written by ICBs in partnership with NHS England. The group has worked together at pace to develop a shared vision of the future with a view to providing clarity on the direction of travel and a consistent understanding of the future role and functions of ICBs.

The delivery of the 10 Year Health Plan will require a leaner and simpler way of working, where every part of the NHS is clear on its purpose, what it is accountable for, and to whom. We expect the 10 Year Health Plan to set out more detail on the wider system architecture and clarify the role and accountabilities of trusts, systems, and the centre of the NHS.

We are sharing this blueprint with you today without the corresponding picture of what the future of neighbourhood health will look like or the role of the centre or regional teams.

We are also sharing this now without the benefit of the wide engagement with staff and stakeholders that will be required to get the detail and implementation right. Given the pace at which this work has been developed over recent weeks, our initial focus has been system-led design. We are now sharing it more widely for discussion and refinement and will be setting up engagement discussions over the coming weeks.

This blueprint document marks the first step in a joint programme of work to reshape the focus, role and functions of ICBs, with a view to laying the foundations for delivery of the 10 Year Health Plan. It is clear that moving forwards, ICBs have a critical role to play as strategic commissioners working to improve population health, reduce inequalities and improve access to more consistently high-quality care and we look forward to shaping the next steps on this together.

1. Context

In July 2022, Integrated Care Boards (ICB) were established with the statutory functions of planning and arranging health services for their population, holding responsibility for the performance and oversight of NHS services within their footprint. Alongside these system leadership and commissioning roles, they were also set up with a range of delivery functions, including emergency planning, safeguarding and NHS Continuing Healthcare assessment and provision.

As the Darzi review noted[1], since 2022, there have been differing interpretations of the role of ICBs, with some leaning towards tackling the social determinants of health, some focused on working at a local level to encourage services to work more effectively together, and some focused on supporting their providers to improve (in particular) financial and operational performance. The wider context, including performance measures focused on hospitals and the requirement for ICBs to ensure their Integrated Care System (ICS) delivers financial balance, mean that ICBs have found it hard to use their powers to commission services in line with the four ICS objectives. This has largely resulted in the status quo with increasing resources directed to acute providers, when the four objectives should have instead led to the opposite outcome.

As the Darzi review concludes, the roles and responsibilities of ICBs need to be clarified to provide more consistency and better enable the strategic objectives of redistributing resource out of hospital and integrating care. Crucial to this is a rebuilding of strategic commissioning capabilities, requiring "*as strong a focus on strategy as much as performance*" and a parallel investment in the skills required to "*commission care wisely as much as to provide it well*".

The 10 Year Health Plan will reinforce the criticality of this role and the Secretary of State is clear about his desire – and the need – to deliver the three shifts. The NHS needs to deliver better value for its customers – the population of England. This means increasingly focusing on prevention and reducing inequalities, delivering more services in a community/ neighbourhood based setting – and ensuring all services are delivered as efficiently and effectively as possible, in particular through the use of technology.

Across the NHS, these three strategic shifts form the foundation of the Model ICB's approach to transformation and redesign:

- **treatment to prevention:** A stronger emphasis on preventative health and wellbeing, addressing the causes of ill health before they require costly medical intervention and

[1] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

reducing inequalities in health. This involves proactive community and public health initiatives, working closely with local authorities, to keep people healthy.

- **hospital to community:** Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
- **analogue to digital:** Harnessing technology and data to transform care delivery and decision-making. From digital health services for patients, to advanced analytics (population health management, predictive modelling) for planners, the focus is on smarter, more efficient, and more personalised care.

These shifts set the direction for how ICBs need to operate going forward. The NHS needs strong commissioners who can better understand the health and care needs of their local populations, who can work with users and wider communities to develop strategies to improve health and tackle inequalities and who can contract with providers to ensure consistently high-quality and efficient care, in line with best practice.

This document, developed by a working group consisting of ICB leaders from across the country, sets out a blueprint for how ICBs can operate within a changing NHS landscape. It covers the following areas:

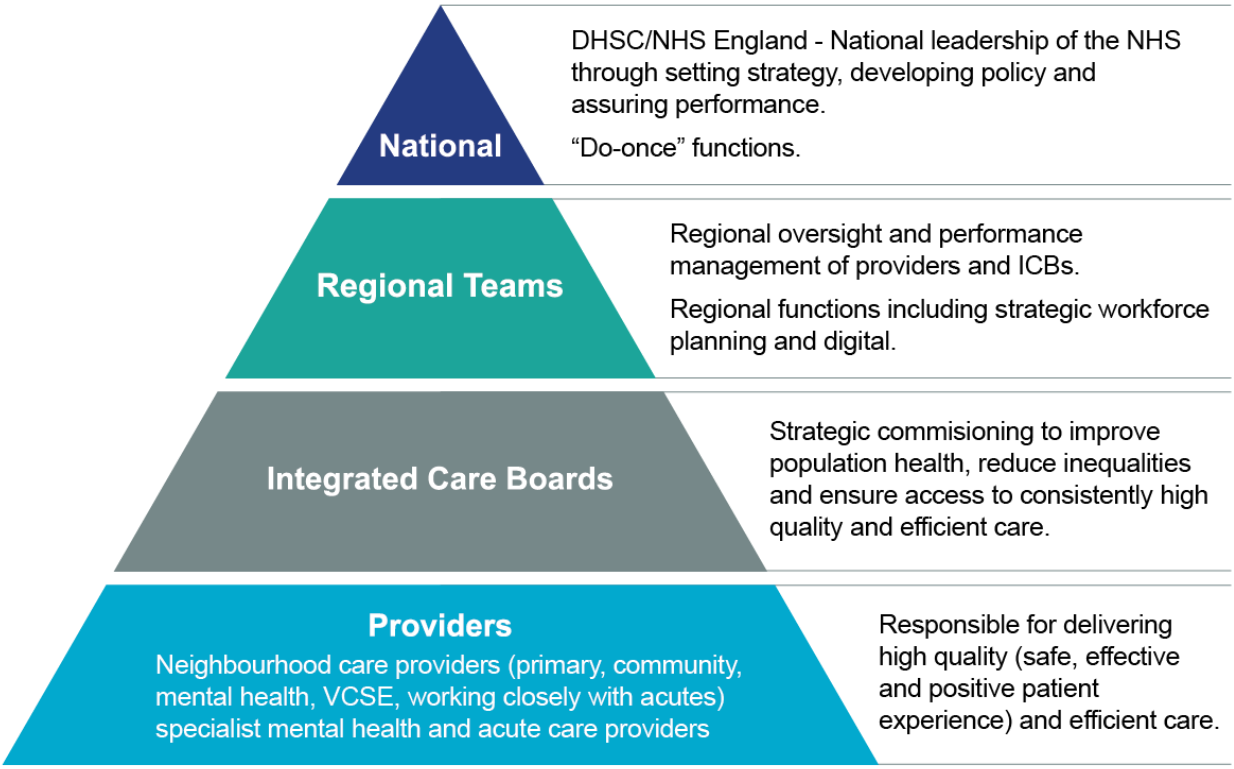
- **purpose** – why ICBs exist
- **core functions** – what they do
- **enablers and capabilities** – what needs to be in place to ensure success
- **managing transition** – supporting ICBs to manage this transition locally and the support and guidance that will be available.

2. Purpose and role: why ICBs exist

ICBs exist to improve their population's health and ensure access to consistently high-quality services. They hold the accountability for ensuring the best use of their population's health budget to improve health and healthcare, both now and in the future.

ICBs provide system leadership for population health, setting evidence based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from the available resources. This involves investing in, purchasing and evaluating the range of services and pathways required to ensure access to high quality care, and in order to improve outcomes and reduce inequalities within their footprint. ICBs not only commission services but also align funding and resources strategically with long-term population health outcomes and manage clinical and financial risks.

The refreshed role of ICBs has been developed through a set of assumptions about a refreshed system landscape, along the lines set out below:



3. Core functions: What ICBs do

To deliver their purpose, ICBs focus on the following core functions:

The following table summarises the activities that make up these core functions.

Model ICB core functions and activities	
Activity	**Detail**
1. Understanding local context: assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision	
Population data and intelligence	• Using data and intelligence (including user feedback, partner insight, outcomes data, public health insight) to develop a deep and dynamic understanding of their local population and their needs and how these are likely to change over time • Leveraging real-time data and predictive modelling to identify risk, understand variation, and direct resources where they will have the greatest impact (allocative efficiency) • Segmenting their population and stratifying health risks • Dis-aggregating population health data to surface inequalities, generate actionable insights, inform service design and deployment and scrutinise progress towards equity
Forecasting and modelling	• Developing long-term population health plans using epidemiological, actuarial, and economic analysis • Forecasting and scenario modelling demand and service pressures • Understanding current and future costs to ensure clinical and financial sustainability • Convening people, communities and partners to challenge, critique and inform population health plans, demand modelling and cost forecasts
Reviewing provision	• Reviewing current provision using data and input from stakeholders, people and communities • Building a deep understanding of operational performance, quality of care (safety, effectiveness, user experience) and productivity/unit cost across all providers
2. Developing long term population health strategy: Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence	
Developing strategy with options for testing and engagement	• Drawing on a variety of inputs (analysis of population health needs, evidence base on what works, national and international examples, user priorities, innovation and horizon scanning, bottom-up costing, principles of healthcare value, impact/feasibility analysis) to develop strategic options for testing and engagement with partners, people and communities • Developing and agreeing best practice care pathways with partners, people and communities, using national guidance and working closely with local clinical leaders to inform this

	• Aligning funding with need and impact using locally adapted actuarial models and bottom-up costing (“should cost” principles) • Ensuring efficiency and equity using value-based approaches to prioritisation, underpinned by public health principles
Setting strategy	• Setting overall system strategy to inform allocation of resources to maximise improved health and access to high quality care (safety, effectiveness, user experience), shifting focus from institutions to population outcomes, and targeting health inequalities by improving equity of access, experience and outcomes • Determining where change is required, the priority outcomes for improvement and population metrics to track • Co-producing strategy with communities, reflecting unmet needs and targeting inequalities • Designing new care models and investment programmes and co-ordinating major transformation programmes • Collaborating with local authorities, place-based partnerships, provider collaboratives, academia, think tanks, and analytics partners to develop and refine strategy
3. Delivering the strategy through payer functions and resource allocation: oversight and assurance of what is purchased and whether it delivers outcomes required	
Strategic purchasing	• Aligning funding to needs using data-driven models • Defining outcome-linked service specifications • Setting strategic priorities for quality assurance and oversight, developing policies and frameworks for quality improvement • Prioritising interventions to address health inequalities
Market shaping and management	• Understanding the different costs and outcomes of a range of providers • Building robust “should cost” and “should deliver” models to test against • Introducing and encouraging new providers where gaps exist in the market, for example, frailty models • Working with providers to understand factors necessary for sustainability, for example, the link between elective orthopaedics and trauma • Exploring a range of payment mechanisms
Contracting	• Negotiating and managing outcome-based contracts • Monitoring provider performance and benchmarking services with continuous review of impact, access and quality • Using performance frameworks, invoice validation • Establishing procurement governance, value-for-money checks

Payment mechanisms	• Designing incentives (blended payments, gainshare, shared savings) to improve equity, efficiency and productivity • Implementing risk mitigation strategies (for example, collaborative risk-pools) • Using financial stewardship tools (cost-effectiveness thresholds, return on investment) • Deploying payment models to improve equity (for example, blended payments linked to reducing inequalities)
4. Evaluating impact: day-to-day oversight of healthcare utilisation, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes	
Utilisation management	• Day-to-day oversight of service usage using real-time dashboards (admissions, urgent and emergency care attendances, prescribing, coding etc.) • Identifying unwarranted care variations utilising benchmarking tools and clinical audits and unwarranted over treatment, for example cataracts • Convening clinical reviews and managing complex cases • Optimising care pathways with providers
Evaluating outcomes	• Evaluating the outcomes from commissioned services • Rigorous monitoring of priority metrics, identifying unwarranted variation and clear feedback loops to inform commissioning adjustments and understand the return on investment • Establishing feedback loops for adaptive planning • Embedding feedback from people and communities, staff and partners into evaluation approaches
User feedback, co-design and engagement	• Evaluation, co-design and deliberative dialogue with people and communities, using design thinking methodologies • Ensuring user feedback mechanisms are embedded in how resource is allocated and evaluated
Governance and Core Statutory Functions: Ensures the ICB is compliant, accountable, and safe	
Ensuring the ICB is compliant, accountable and safe	• Establishing robust governance structures and processes to ensure legal compliance, transparency and public accountability • Fulfilling statutory duties (for example, equality, public involvement) and monitoring of equity outcomes alongside access, quality, and efficiency • Implementing strong clinical and information governance and effective financial and risk management systems • Maintaining business continuity and emergency planning • Overseeing delegated functions with proportionate assurance

ICB functional changes

To support the development of the future state, ICBs should consider the following assumptions about some of the functional changes that could happen. We are sharing this to provide an indication of the future state, however the detail and implementation will depend on multiple factors, including engagement and refinement with partners, the parallel development of provider and regional models, readiness to transfer and receive across different parts of the system and, in some cases, legislative change.

ICBs will need to work closely with their staff to ensure they are supported, to retain talent and to safely manage delivery across the wider system and public sector, including when functions move to different parts of the landscape.

Given the implications of these functional changes on different parts of the system, next steps will need to be developed by working closely with partners nationally and within local systems over the coming months. In light of this, no specific timeframes are provided at this stage.

ICB functional changes		
Change to manage	**Functions in scope**	**Guiding notes**
Grow: functions for ICBs to grow / invest in over time to deliver against the purpose and objectives	Population health management – data and analytics, predictive modelling, risk stratification, understanding inequalities	• Essential for core role and activities • Can be delivered within existing legislation • Will require investment in new capabilities over time
	Epidemiological capability to understand the causes, management and prevention of illness	
	Strategy and strategic planning including care pathway redesign	
	Health inequalities and inclusion expertise – capacity and capability to routinely dis-aggregate population and performance data to surface health inequalities, generate actionable insights, drive	

	evidence informed interventions and build intelligence to guide future commissioning and resource allocation decisions	
	Commissioning neighbourhood health	
	Commissioning of clinical risk management and intervention programmes (working with neighbourhood health teams to ensure proactive case finding)	
	Commissioning end-to-end pathways (including those delegated by NHS E: specialised services; primary medical, pharmacy, ophthalmic and dental services (POD); general practice, and further services that will be delegated by NHS England to ICBs over time) *Vaccinations and screening will be delegated by NHS England to ICBs in April 2026* *All remaining NHS England direct commissioning functions will be reviewed during 2025/26*	
	Core payer functions – strategic purchasing, contracting, payment mechanisms, resource allocation, market shaping and management, utilisation management	
	Evaluation methodologies and evidence synthesis using qualitative and quantitative data, feedback and insights	

	User involvement, user led design, deliberative dialogue methodologies	
	Strategic partnerships to improve population health (public health, local partners, VCSE, academia, innovation)	
Selectively retain and adapt: functions for ICBs to retain and adapt including by delivering at scale	Quality management – understanding drivers of improved health, range of health outcome measures, elements of high-quality care (safety, effectiveness, user experience); child death reviews	• Embed in commissioning cycle, monitoring of contracts • Avoid duplication with providers, regions and CQC • Use automated data sources and single version of the truth
	Board governance	• Look to streamline Boards to deliver core role as set out • Headcount should be reduced at Board level with the right roles and profiles to deliver core Model ICB functions
	Clinical governance	• Strengthen focus on embedding management of population clinical risk, best practice care pathways in commissioning approach
	Corporate governance (including data protection, information governance, legal services)	• Maintain good governance practice; look to deliver some functions at scale across ICBs
	Core organisational operations (HR, communications, internal finance, internal audit, procurement, complaints, PALs)	• Look to streamline and deliver some functions at scale
	Existing commissioning functions, including clinical policy and effectiveness – local funding decisions (individual funding	• Will be built into new commissioning/payer functions operating at ICB and pan-ICB level

	requests; clinical policy implementation)	
Review for transfer: functions and activities for ICBs to transfer over time, enabled by flexibilities under the 2022 Act for ICBs to transfer their statutory duties	Oversight of provider performance under the NHS performance assessment framework (finance, quality, operational performance)	• Performance management, regulatory oversight and management of failure to transfer to regions through the NHS Performance and Assessment Framework • Market management and contract management functions to be retained and grown in ICBs
	Emergency Preparedness, Resilience and Response (EPRR) and system coordination centre	• Transfer to regions over time
	High level strategic workforce planning, development, education and training	• Transfer to regions or national over time, retain limited strategic commissioning overview as part of strategy function
	Local workforce development and training including recruitment and retention	• Transfer to providers over time
	Research development and innovation	• Transfer to regions over time, with ICBs retaining and building strategic partnerships to support population health strategy
	Green plan and sustainability	• Transfer to providers over time
	Digital and technology leadership and transformation	• Transfer digital leadership to providers over time enabled by a national data and digital infrastructure
	Data collection, management and processing	• Transfer to national over time
	Infection prevention and control	• Test and explore options to streamline and transfer some activities out of ICBs

	Safeguarding	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	SEND	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Development of neighbourhood and place-based partnerships	• Transfer to neighbourhood health providers over time
	Primary care operations and transformation (including primary care, medicines management, estates and workforce support)	• Transfer to neighbourhood health providers over time
	Medicines optimisation	• Transfer delivery to providers over time, retain strategic commissioning overview as part of strategy function
	Pathway and service development programmes	• Transfer to providers, retain strategic commissioning overview as part of strategy function
	NHS Continuing Healthcare	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Estates and infrastructure strategy	• Transfer to providers over time, retain limited strategic commissioning overview as part of strategy function
	General Practice IT	• Explore options to transfer out of ICBs ensuring consistent offer

4. Enablers and capabilities: what ICBs need to ensure success

For an ICB to effectively perform the core functions set out in section 3, several key enablers need to be in place. A high-level summary of these is set out below:

- **Healthcare data and analytics –** to enable ICB decisions to be guided by population health data and insights, ICBs will need to develop strong population health management approaches underpinned by robust data capability. This will need to include developing the capabilities to segment the population and stratify risk and build a person-level, longitudinal, linked dataset integrating local and national data sources alongside public and patient feedback. There will need to be appropriate data-sharing and governance agreements to track individuals' journeys across health and care (to understand needs and outcomes holistically); and deploy predictive modelling to foresee future demand, cost and impact of interventions. ICBs will need to cultivate teams with the ability to analyse and interpret complex data (health economists and data-scientists) and deploy data-driven techniques (such as modelling the return on investment for preventative interventions). Data can be integrated reliably between services to provide real-time, accurate data enabling better decision-making and interoperability – the NHS Federated Data Platform (FDP) will be crucial to enable this work, and should be used as the default tool by ICBs.

- **Strategy –** ICBs will need to develop effective strategy capability, comprised of individuals with good problem solving and analytical skills. They will need to foster a greater understanding of value-based healthcare alongside the ability to synthesise a range of information (qualitative and quantitative) and develop actionable insights to support prioritisation. ICBs will need strategic leaders who can diplomatically and collaboratively work with a range of partners including by facilitating multi-agency forums and collaborative decision-making. They will also need the ability to navigate and synthesise complexity so that people and communities, staff and partners can understand the full picture, and be able to draw people together around the shared goal of improving population health.

- **Intelligent healthcare payer –** for ICBs to develop into sophisticated and intelligent healthcare payers, they will need to invest in their understanding of costs ('should cost' analysis) and wider finance functions, developing capabilities in strategic purchasing, contracting, design and oversight of payment mechanisms, utilisation management and resource allocation. This will need to include commercial skills for innovative contracting and managing new provider relationships. ICB staff will need to learn how to proactively manage and develop the provider market, using procurement and contracting levers to incentivise quality improvement and innovation. This should involve techniques that ensure effective use of public resources so that investment decisions are guided by

relative value, not just demand or precedent. This calls for deliberate use of tools such as programme budgeting and decommissioning frameworks to support allocative efficiency.

- **User involvement and co-design –** for services to truly meet communities' needs, people must be involved from the very start of planning through to implementation and review. Each ICB should have a systematic approach to co-production – meaningfully involving patients, service users, carers, and community groups in designing solutions. This goes beyond formal consultation and means working with people as partners. ICBs will need to ensure that focused effort and resources are deployed to reach seldom heard and underserved people and communities, working with trusted community partners to achieve this. Ultimately, this enabler is about shifting the relationship with the public from passive recipient to active shaper of health and care, with a particular focus on underserved communities.

- **Clinical leadership and governance –** ICBs will need effective clinical leadership embedded in how they work, ensuring they have a solid understanding of population clinical risk and of the best practice care pathways required to meet population needs and improve outcomes. Clinical governance and oversight will be crucial in ensuring that the decisions that ICBs make are robust, particularly regarding the prioritisation of resources. Contract management of commissioned services will need to include effective quality assurance processes.

- **System leadership for population health –** effective system leadership will be essential to driving improvements in population health. ICB leaders and staff need to be adept at system thinking, analytics, and collaboration. They will need to work diplomatically and be comfortable driving change and influencing without direct authority. ICBs should develop and foster strategic partnerships across their footprints with a range of partners (including academia, VCSE, innovation), alongside working together with providers and local government as they develop and implement their strategies.

- **Partnership working with local government –** recognising the critical and statutory role of local authorities in ICSs and as partner members of ICBs, engagement and co-design with local government will be critical to the next phase of this work. Linked to this, is the need for ICBs to continue to foster strong relationships with the places within their footprint, building a shared understanding of their population and working together to support improved outcomes, tackle inequalities and develop neighbourhood health. We will be working jointly with the Local Government Association to take this development work forwards.

- **Supporting ICB competency and capability development – national support offer and maturity assessment –** it is proposed that a national programme of work, including

a new commissioning framework, is developed to ensure ICBs have the necessary capabilities and competencies to discharge their functions effectively. This should be developed by learning from successful international models and World Class Commissioning and form the basis of future assessments of ICB maturity.

5. Managing the transition

The ask on ICBs is significant this year as they work to maintain effective oversight of the delivery of 2025/26 plans, build the foundation for neighbourhood health and manage the local changes involved with ICB redesign, including supporting their staff through engagement and consultation.

To support with this, the following sections set out some high-level principles around:

- delivering ICB cost reductions plans and realising the savings
- managing the impact on staff
- designing leadership structures of ICBs
- managing risk during transition through safe governance
- expectations for safe transition of transferred functions

Delivering ICB cost reductions plans and realising the savings

ICBs will need to use this guidance to create bottom-up plans which are affordable within the revised running cost envelope of £18.76 per head of population. More details on this are set out below:

- the calculations to derive the £18.76 operating cost envelope include all ICB running costs and programme pay (only excluding POD and specialised commissioning delegation)
- the reduction in ICB costs to meet this target must be delivered by the end of Q3 2025/26 and recurrently into 2026/27
- ICBs are encouraged to expedite these changes as any in-year savings can be used on a non-recurrent basis to address in-year transition pressures or risks to delivery in wider system operational plans and potentially sooner to mitigate and de-risk financial plans
- there will be flexibility at an ICB-level, as some inter-ICB variation may be warranted and will need to be managed within a region to account for hosted services, however we expect delivery of the target at an aggregate regional level
- generating savings cannot be a cost shift to a provider unless overall there is the saving, for example, a provider takes on an ICB operated service and therefore requires circa 50% less cost in line with the £18.76 running cost envelope

We recognise that not all functional changes to reach the Model ICB can be done this year as some changes will require legislation and any transfer arrangements will need to be

carefully managed to ensure safe transition. Recognising this, we anticipate that most savings will come from streamlining approaches, identifying efficiency opportunities – through benchmarking, AI and other technological opportunities and from at scale opportunities afforded through greater collaboration, clustering and where appropriate, eventual merger of ICBs. Principles to apply to footprints, clustering and mergers will be communicated and coordinated by regional teams.

NHS England is providing a planning template to facilitate the May 2025 plan returns. This will be issued in the week commencing 6 May 2025. Plans should be submitted to your regional lead by 5pm on **30 May 2025**. Plans will set out how each ICB intends to achieve the £18.76 operating cost envelope and will then go through a national moderation process (involving a confirm and challenge process) to support consistency of approach and sharing of opportunities. These plans should be informed at a high level by the vision set out in this blueprint.

Support for managing the impact on staff

A national support offer will be available to ensure fair and supportive treatment of staff affected by the transition. This includes advice on voluntary redundancy and Mutually Agreed Resignation Schemes (MARS), along with guidance on redeployment and retention where appropriate. Funding mechanisms to support these options will be clarified centrally ensuring local systems can manage workforce changes consistently. Emphasis will be placed on transparent, compassionate communication and engagement to retain talent and maintain morale through the change process. We will work in partnership with trade union colleagues to implement the change for staff.

Advice on leadership structures of ICBs

ICBs are expected to maintain clear, accountable leadership with effective governance during the transition and beyond. ICBs should look to streamline Boards and reduce headcount at Board level to deliver core purpose and role as described. Leadership structures and executive portfolios should also reflect the functions as set out above, including skills in population health data and insights, strategic commissioning (including strategy, partnerships and user involvement), finance and contracting and clinical leadership and governance. At Board level, a strong non-executive presence is encouraged to support both oversight and the delivery of transition priorities.

Managing risk during transition through safe governance

To ensure a safe and coherent transition, each ICB should establish a dedicated Transition Committee, including both executive and non-executive members. These committees will take responsibility for managing local risks, tracking progress, and overseeing the development of organisational design and implementation of change processes.

To support this work, a central NHS England programme team — under the leadership of an Executive SRO — will be set up to provide coordination, support and a check and challenge process on ICB plans. This will seek to ensure appropriate support guidance is developed to facilitate the transition, share best practices, and facilitate consistency across systems to deliver the vision set out here. This central support will also help ICBs navigate legal, operational, and workforce challenges while ensuring focus remains on delivery of statutory duties throughout the transition.

Expectations for safe transition of transferred functions

Safe transition of functions is critical to the success of the new Model ICB design and the future system landscape. To manage this transition effectively, an assessment of readiness is necessary for both the sender and the receiver. Implementing a gateway process will help verify readiness before transferring staff and functions underpinned by clear governance frameworks, outcome metrics, financial risk arrangements, and escalation protocols to ensure safe and effective delivery.

NHS England is currently developing the operating model for the Model Region. We will continue to work with ICBs as we develop the regional approach to ensure alignment with the Model ICB design and implementation. We have been clear that performance management of providers against the NHS Performance and Assessment Framework (NPAF) will transfer to Regions under the new design. It will be important to be clear on responsibilities as these functions transfer. Once transferred ICBs will oversee providers through their contracting arrangements but will not be responsible for leading the regulatory oversight of providers against the NPAF.

Frequently asked questions

FAQs covering all aspects of transition is being developed to support ICBs as they manage these elements locally.

Please direct any questions to england.Model-ICB@nhs.net and we will use these to inform future sets of FAQs.

HEALTH AND WELLBEING BOARD: 29 MAY 2025

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

NEIGHBOURHOOD HEALTH PROGRAMME

Purpose of report

1. The purpose of this report is to inform the Board of the progress made to date with implementing the Neighbourhood Health Programme in Leicestershire.

2. The report details the current in-year plans and refers to the commitment to work in partnership to develop 5 and 10 year plans to develop the neighbourhood model of care.

Recommendation

3. The Board is recommended to:

   (a) Note the progress made thus far;

   (b) Support the direction of travel outlined in the report.

Policy Framework and Previous Decision

4. NHS England published 'Neighbourhood health guidelines 2025/26' on the 29 January 2025 which set out guidelines to provide integrated care boards (ICBs), local authorities and health and care providers with more specificity to help them progress neighbourhood health in 2025/26 in advance of the publication of the 10 Year Health Plan.

5. These guidelines outline the NHS England belief that the foundations of a neighbourhood health service are already in place in many areas across the country and are made up of 6 core components:

   a. Population Health Management;

   b. Modern General Practice;

   c. Standardising Community Health Services;

   d. Neighbourhood Multi-Disciplinary Teams;

   e. Integrated intermediate care with a 'Home First' approach;

f. Urgent neighbourhood services.

6. The Neighbourhood health guidelines require systems to:

- Standardise the 6 core components of existing practice to achieve greater consistency of approach.
- Bring together the different components into an integrated service offer to improve coordination and quality of care, with a focus on people with the most complex needs.
- Scale up to enable more widespread adoption.
- Rigorously evaluate the impact of these actions, ways of working and enablers, in terms of both outcomes for local people and effective use of public money.

7. ICBs and local authorities were asked to jointly plan a neighbourhood health and care model for their local populations that consistently delivers and connects the initial core components at scale, with an initial focus on people with the most complex health and care needs.

8. This report will provide an update against these requirements, outline next steps for the neighbourhood health programme, and discuss the ongoing risk to robust evaluation.

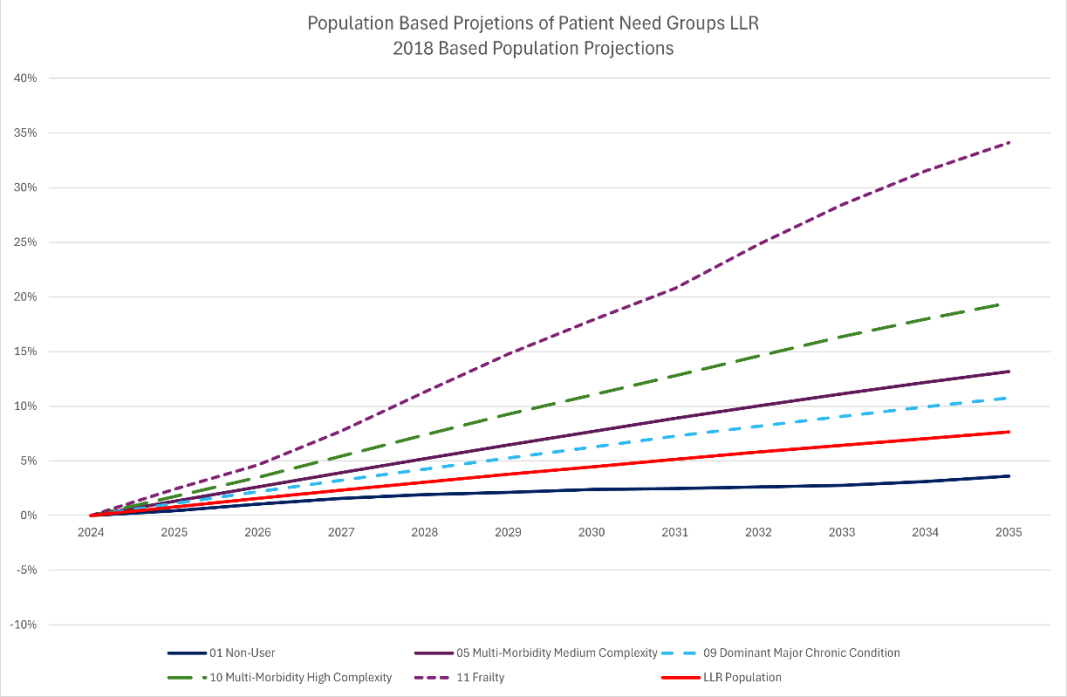
Background

9. The LLR system has been working at place and neighbourhood level since the advent of the Better Care Fund. Based on previous delivery of outcomes, the system remains in a good position to embrace the challenges of neighbourhood health, having embedded a population health management system, a significant Home First programme of care, a nationally lauded Intermediate care programme and neighbourhood health and care plans, covering LLR. Each of these has focussed, over a number of years, across both physical and mental health care.

10. However, since the workstreams were combined with Urgent and Emergency Care (UEC), the work of these programmes has largely been unsighted or understood in detail. There is a danger of work not being fully aligned or being duplicated, learning not being shared and the full benefit of these services not being fully delivered. Equally, the benefits from each of these has not been transacted within or across provider contracts, leaving triangulation of any return on investment unaccounted for. There is significant opportunity to bring these together, therefore, in a single, coordinated programme for this area, with senior executive oversight.

Leicester, Leicestershire & Rutland – local context

11. However developed the local work, it is clear that this will not be enough to meet the demands on services over the next 10 years. The chart below shows the expected growth in each of our 'patient need groups' up until 2025:



12. It is apparent that without a radical change to the models of care across Leicester, Leicestershire and Rutland (LLR), this model will continue to compromise equity of access, equity of outcome and equity of experience. The opportunity of delivering this programme collectively is significant – both for our patients and our colleagues working across health and care services.

13. To this end, a key outcome from the ICB Board Development Session in January 2025 was a commitment across all partners that delivering 'Neighbourhood Health' must be our predominant mindset. We agreed that we would decisively deliver a model of neighbourhood health in 2025/26, building on everything that we have in place already, and that simultaneously we would commit to a jointly designing and delivering a radical model of care, fit for the future.

14. Since this session, a Neighbourhood Health Programme Board has been set up to design and deliver the NHS mandate requirements, chaired by Prof. Aruna Garcea, Associate Medical Director for primary care at University Hospitals of Leicester NHS Trust and Chair of the Primary Care Network at the NHS Confederation. Executive lead for the programme sits with Rachna Vyas, Deputy Chief Exec/Chief Operating officer, NHS LLR ICB. Terms of reference

have been drafted, with a full partnership approach, including a patient reference group, with the Programme Board meeting in April 2025. A clinically led visioning workshop is then planned for June 2025 to begin work on the 10-year model, in line with the three shifts outlined by government.

15. Engagement has been ongoing since January, through a combination of system, place (inc. local government) and organisational-specific sessions, tailored to ensuring alignment between plans. What has been clear through these sessions is that the understanding around each component of the neighbourhood health model is variable across the system and whilst the model has evidenced a tangible reduction in activity, this has not been visible within and across the system.

Headline progress against the NHS England guidelines

16. Given the pressing UEC demands and the ongoing financial challenges, the 2526 plan for neighbourhood health has specifically targeted interventions that will support admission and attendance avoidance, and/or support flow across provider services.

17. The 2025-26 plans include the following specific deliverables:

- 100% of practices will have stratified their population by patient need group in Q1. 75% of practices will have started to use this data to manage their workflow by September 2025.
- 15,984 more care plans for those in patient need groups 5, 9, 10, 11 will be completed by 31st March 2026.
- The same-day access model of care will be implemented, creating an additional 100 appointments per day for patients streamed from the emergency department.
- A single frailty pathway across community and acute care will be in place by Q2 2526 and a 15% increase in the capacity for the falls service from April 1st, 2025.
- An integrated pathway for GP referred multi-morbid patients will be in place by 1st October 2025, jointly across UHL, LPT and general practice.
- An integrated service pathway for chronic kidney disease, cardio-metabolic and respiratory illness (INTERSTELLAR) will be in place by 1st October 2025, jointly across UHL and the community.
- 11 Integrated Neighbourhood Teams, with 100% coverage of LLR, will be functional by June 2025, focussing on the patient need groups with the highest levels of unwarranted variation.
- The Integrated Discharge function will be functionally aligned to the System Coordination Centre, ensuring that no more than 100 patients are awaiting a care plan each day by July 1st, 2025

18. Each of these interventions have been clinically designed / practitioner designed with value for money, patient flow, and patient outcome at the heart of

the service. Again, to really capitalise on the opportunity presented through the neighbourhood health model, there is far more to do, collectively. Headline evidence gathered locally, links to 2025-26 plans and further opportunities are outlined below, for each of the six components of neighbourhood health.

Population health management

19. LLR providers have been utilising the 'ACG risk stratification' system for many years. The system is embedded within General Practice and has been used to identify at-risk groups more effectively and deploy resources where they make the biggest difference.

20. Our local scheme, devised by local LLR GP's, focusses predominantly on care planning with our multi-morbid population in specific patient need groups, (known as PNG's). Thus far, over 100,00 care plans have been put in place, with 78% of patients in the highest PNG holding care plans. Local analysis shows that patients without care plans in this group have 36% higher Emergency Department attendances and a 54% higher rate of non-elective admissions.

21. In 2024/25, 15,984 plans were planned to be put into place – 11,843 have been delivered year-to-date, with the shortfall attributed to collective action.

22. Our 2025/26 plan includes delivery of an additional 15,984 plans, largely in our higher risk and therefore higher impact PNG's. Resource for General Practice to conduct this activity through the year is in place.

23. The opportunity here is **scale**; further resource will support appropriate levels of patients in each PNG have high quality care plans, thereby reducing the likelihood of acute activity.

Modern General Practice

24. This programme has two components – contact and single workflow. Our local programme also include workforce growth, in recognition of local GP shortages.
    a. Contact – All contact standards for 2425 have already been met, including upgrading of phone systems, implementation of online services and appointment levels.
    b. Single workflow – The 2024-25 plan to pilot 'Rapid Health' is live across 1 Federation, 1 county practice and 1 City practice, with efficacy, scalability, and practice & patient feedback being collected. Current plans for 2025-26 involve scaling the county pilots to cover c90,000 patient population; however, whether this is enacted will depend on assessment of the above.
    c. Workforce growth – In 2023-24, the patient to GP ratio for Leicester City was 3,262 patients per GP, with the regional patient to GP ratio at 2,266. 29 GP's have been recruited into LLR, with a resulting reduction in this ratio. As at Dec 24, patient to GP ratio in Leicester City was 2,829 registered patients to each WTE GP, East

Leicestershire has 2,099 patients to each WTE GP and West Leicestershire had 2,154 patients to each WTE GP.

25. For 2025/26, further workforce recruitment plans are in place, with an expected 8 additional GP's expected to come into the system.

26. The opportunity here is to enact a whole system plan to attract an increased **level of GP workforce** into LLR, through offering combined roles between general and specialty medicine.

Community health services – Home First / Urgent community services

27. This component is perhaps the most complicated but remains the area of significant opportunity to realise the benefits of integration. In 2024-25, the plan was to continue the key areas of focus (admission avoidance services for specific cohorts of patients) and to begin to integrate the offers for all pre-hospital services.

28. In 2024-25, YTD each service line has achieved its trajectory of activity and clinical audits continue to show efficacy. For example, between April 2024 and Dec 2024, our pre-hospital service saw 2,089 patients, with clinical audit showing 1,420 ED attends prevented and over 10,000 bed days saved.

29. The plans for 2025/26 will scale these opportunities and integrate them into one, single service offer, covering all pre-hospital pathways. New pathways include a single frailty pathway across community and acute care in place by Q2 2526 and a 15% increase in the capacity for the falls service from April 1st.

30. The opportunity here is understanding how **acute services can support this integration** across health and care further – particularly with the advent of Same Day Emergency Care services.

Integrated Neighbourhood Teams

31. Integrated Neighbourhood Teams have been in place in various guises for some time across LLR. In 2024-25, these were reformulated to cover physical and mental health across each of the 8 neighbourhoods in Leicestershire County and Rutland. City INT's have been re-cast based on 4 'health needs neighbourhoods' and this will be the proposed footprint for 2025-26 across LLR.

32. In 2024/25, the LUCID pilot has improved care pathways for 1,984 patients. Outcomes include: 232 (12%) high risk people had referral expedited; 179 (9%) secondary care referrals deferred through advice in a virtual clinic; 986 (50%) consultations with a new management plan devised and 1157 (58%) Advice and Guidance requests avoided. Business intelligence modelling indicates in 5 years, we could prevent 317 CVD events; 102 new strokes and 14 premature deaths.

33. For 2025/26, the long terms conditions programme is focussing on the implementation of a cardio renal-metabolic approach to multi-morbidity, an integrated respiratory neighbourhood model of care, and complex care planning, all to support a reduction in short stay admissions for this cohort. This relies on secondary care working with place and neighbourhood teams on management of population health in a much wider, holistic sense.

34. The opportunity here is a **move from reactive care to more preventative and proactive care**, based on the risk stratified population in each neighbourhood. Customising care delivery to the unique needs of a community, from prevention to chronic care management, ensures interventions resonate locally and focus on equity of access and outcome in a meaningful manner.

Integrated Intermediate care

35. This is one of the strongest and most collaborative parts of the programme, with national and regional teams regularly seeking to understand the LLR approach and model.

36. For 2024-25, our aspiration was to reduce the number of patients classified as medically optimised for discharge (MOFD) awaiting plans compared to the same point in the previous year, despite over 100 extra acute beds being open in 2425. Looking at Jan 24 vs Jan 25, there were on average 20 less patients awaiting plans daily. For pathway 2, in Jan 24, we saw an average of 108 patients waiting for a pathway 2 discharge – in Jan 25, this had reduced to 67 patients.

37. For 2025-26, plans have been set with our local authority partners which push delivery further, faster. For example, 90% of discharge plans are expected to be in place within 48 hours of referral for pathway 2 and the numbers of plans given daily for each pathway are also expected to increase to meet demand.

38. The opportunity here remains **scaling of triage services at point of ward referral & increasing Pathway 1 capacity**. Currently, 8% of patients are discharged onto pathway 2; this is 4% nationally.

Overall programme for 2025/26

39. The overall programme plan for 2526 is in place, with named leads for each action, a lean governance structure to support delivery, dual reporting into the UEC collaborative and the NH Programme Board and oversight through the LLR Integrated Care Partnership.

40. As place groups will drive the delivery of the vast majority of this work for their respective populations, regular reporting is also scheduled for each Health and Wellbeing Board.

41. All activity assumptions have been clinically validated through the Clinical Responsibility Group, led by Prof Damian Roland and validated by individual clinical leads.

42. Interdependencies with each of the Partnerships and collaboratives are being assessed with each lead and will inform the wider strategy.

43. Risks and escalations will be fed through the exec SRO as required.

Considerations

44. To ensure robust evaluation, transparent data will be required across the major NHS and care provider contracts; whilst some of these issues have been resolved, further work will be required to evidence delivery in a transparent manner. This remains a risk.

45. Given how far ahead LLR have been reported to be in comparison to other ICB areas, Carnell Farrar, the Health Economics Unit and the NHS Confederation are all interested in supporting evaluation; Business Intelligence leads are supporting this offer to understand which best suits the needs of the ICS.

46. Thus far, the work of the programme has been predominantly focussed on adult pathways. A model of care has been released by the NHS England Children and Young People's team; this is being assessed by relevant partners.

47. The scale of opportunity here is significant; whilst the 2025-26 plan has come together with current knowledge and resources, it is hugely important that the LLR sub-region is ambitious, evidence based and visionary in how we use this opportunity to reset local delivery and radically alter the model of care for those we serve over the next 10 years. To this end, a vision workshop is under development so that the right experts can examine our local health and care projections and design a sustainable service for the future.

County Specific plans

48. In County we have just over 8,000 patients who fall into the PNG cohort of 9,10,11.

    Q1 – Develop a robust implementation programme to support the development of a neighbourhood model.

    Q1 – Identify pilot sites to strengthen the INT model and develop robust MDT approach to supporting patients in PNG cohort 9,10,11 with strong MDT developed care plans (contracts) which identify condition management, wider determinants and support structures, actions to be taken in the event of a related health decline, social support decline, and appropriate care pathways to access.

    Q1 – Ensure an agreed approach to implementation via the Place team working group, and update via Integration Executive.

Q1 – Link neighbourhood model to the refresh of the joint health and wellbeing strategy via the working groups.

Proposals/Options

49. We are developing a neighbourhood model of care across LLR, with Place leading the local implementation of the model.

50. The proposals going forward are as follows::
    a. Building on the foundations laid by the Fuller Stocktake, approaches to tackle health inequalities such as Core20PLUS5 and Core20PLUS5 for CYP, outreach work and using data and local insights, we ask systems to work with partner organisations to:
        - Apply a consistent, system-wide population health management approach to segmentation and risk stratification, to coordinate and deliver appropriate care for population cohorts across providers, and to inform commissioning decisions so that funding is used optimally. This approach should include qualitative as well as quantitative insights and data.
        - Continue to embed, standardise and scale the six initial core components of a neighbourhood health service and ensure capacity across providers is best aligned to optimally meet demand. Systems are asked to deliver the six core components of the model.

51. The plans will be further developed in a workshop scheduled for 3 June 2025.

Consultation/Patient and Public Involvement

52. Patient representative groups are involved in the board and workshop

Resource Implications

53. The plans are being progressed within the current financial envelope.

Background papers

https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/

Circulation under the Local Issues Alert Procedure

Not applicable. The plans apply to the County as a whole.

Appendices – N/A

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LLR Resilience Forum
Leicester, Leicestershire and Rutland

HEALTH AND WELLBEING BOARD: 29TH MAY 2025

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) RESILIENCE FORUM

COMMUNITY RESILIENCE STRATEGY 2024-2028 AND DELIVERY PLAN

Purpose of report

1. The purpose of this report is to provide members of the Health and Wellbeing Board (HWB) an overview of the LLR Community Resilience Strategy (CRS) 2024-2028 and Delivery Plan.

2. The HWB is asked to take note of the CRS, with reference to the Aims, Objectives, Delivery Method and Outcomes, and contribute towards the Delivery Plan in relation to preventative activities and actions that aim to help communities prepare for and reduce the social, financial and wider determinants of health impacts, from emergencies.

Recommendation

3. The recommendations for the Board are:

   (a) to raise awareness of the CRS Strategy 24-25 within your organisations and networks;
   (b) to identify activities and actions from your organisations that could be included in the Delivery Plan;
   (c) to work with LLR Prepared in supporting communities to plan for, respond to and recover from emergencies.

Policy Framework and Previous Decision

4. Public Sector and infrastructure organisations have responsibilities under the Civil Contingency Act 2004 https://www.legislation.gov.uk/ukpga/2004/36/contents to understand, enable and integrate the voluntary capabilities of the public into emergency planning, response and recovery activity. Category 1 responders are the organisations at the core of the response to most emergencies to protect communities and Category 2 responders are the co-operating bodies that are less likely to be involved in the core planning work but may be heavily involved in incidents.

5. The UK Government Resilience Framework https://www.gov.uk/government/publications/the-uk-government-resilience-framework published December 2022 is based on 3 core principles:
   - A **developed and shared understanding** of the civil contingencies risks we face is fundamental;
   - Prevention rather than cure wherever possible: **a greater emphasis on preparation and prevention**; and
   - Resilience is a **'whole of society'** endeavour, so we must be more transparent and empower everyone to make a contribution.

6. LLR Resilience Forum (LRF) https://www.llrresilienceforum.org.uk/ (previously known as LLR Prepared-underwent a change of name and branding Spring 2025) was established in 2004. Its boundaries are co-terminus with Police Force boundaries. The work of the Resilience Forum is overseen by the LRF Executive Board, which is chaired by the Chief Fire Officer for Leicestershire Fire and Rescue Service, its membership is made up of strategic leaders from those with duties under the Civil Contingencies Act 2004.

Background

7. Community Resilience can be defined as the ability of communities and individuals to harness resources and expertise to help prepare themselves for, respond to and recover from emergencies in a way that compliments emergency responders.

8. The communities of LLR are a blend of urban and rural areas that include people from different social, cultural, economic and religious backgrounds. This affects the way emergencies impact at a community, household and individual level. The consequences of different emergencies have the potential to make people vulnerable in different ways.

9. The CRS aligns with the wider work of the LLR Resilience Forum and is owned by the LRF Executive who are drawn from senior officers of the Category 1 Responders.

10. Overseeing the ongoing activities and implementation to the CRS and Delivery Plan is the People and Communities (PCOM) Standing Group, which has representative from Category 1 and 2 responders, voluntary sector responders and partners.

Proposals/Options

11. This Strategy sets out the approach to how LLR Resilience Forum organisations will work with communities and has been bought to the HWB to raise awareness and seek contributions and collaborations. The Strategy advocates an approach to building community resilience which is based on the ideas of social action and community development. Social action is about people coming together to help improve their lives and solve the problems that

are important in their communities. It can include volunteering, giving money, community action or simple neighbourly acts. Community development is the process where community members take collective action on issues that are important to them.

12. Objectives of the Strategy are:
    - Enabling resilient behaviours;
    - Enabling Community Led Social Action;
    - Partnering with voluntary capabilities;
    - Benefits.

13. Approaches to community resilience will be tailored to the characteristics of communities, the varying risk factors and local priorities. The Delivery Plan is where specific actions, events, information and training to meet the Aims, Objectives and Delivery Method will be contained.

14. The Delivery Plan will be delivered by using the 5 'E'S' referenced in the CRS of:
    - Empowerment;
    - Engagement;
    - Education;
    - Enabling;
    - Evaluating.

Consultation/Patient and Public Involvement

15. The CRS went through the LLR Prepared agreed consultation process during Autumn 2024. Feedback was supportive with only minor amendments and clarifications to the draft document suggested.

16. The Strategy was adopted by the LLR Prepared Executive in October 2024

Resource Implications

17. The focus on community resilience must be understood in the context of financial pressures and increasing demand on public services. The reality is that there is less money available and what communities might expect to be the responsibility of, or something that could and should be delivered solely by 'the council' or other public bodies, may not now be the case.

18. The CRS sets out the aims and objectives for working with the communities of LLR. The outcome is that by supporting and enabling individuals, families and communities to be more prepared and resilient to emergencies, the impacts felt by them and the need for public sector resources are reduced.

Conclusion

19. The CRS recognises that it is vital that individuals and communities collaborate on actions alongside public services to support and help their local areas.

These preventative actions will contribute to more prepared, resilient and healthier communities.

20. Members of the HWB are asked for their support in the delivery of the Strategy.

Appendices -

Appendix A Leicester, Leicestershire and Rutland (LLR) Community Resilience Strategy 2024-2028

Appendix B Leicester, Leicestershire and Rutland (LLR) Community Resilience Strategy 2024-2028 Delivery Plan

Officers to contact

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Relevant Impact Assessments

Equality Implications

21. There are no equality implications arising from the recommendations in this report.

Human Rights Implications

22. There are no human rights implications arising from the recommendations in this report.

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Appendix A

LLR Prepared
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Leicester, Leicestershire & Rutland (LLR)

Community Resilience Strategy

2024-2028

Contents

Foreword

Rachna Vyas

Chief Operating Officer, NHS Leicester, Leicestershire & Rutland,
Hon Lecturer, Health Inequalities University of Leicester

Local Resilience Forum Lead for People and Communities (PCOM)

I am delighted to introduce this first Community Resilience Strategy for Leicester, Leicestershire & Rutland.

We have a rich and proud history of coming together and supporting our communities across LLR in times of need. We evidenced this through the pandemic and have since continued to build on the relationships we formed between the public sector and those we serve.

We know that we will face many more risks in the months and years to come – whether these be due to climate events such as fire and flood, human factors such as disorder and civil unrest or newer risks such as cyber-attacks. I am incredibly proud of the mitigations we have collectively put into place to protect our people, our communities and our teams supporting the citizens of LLR – but I'm also acutely aware that there is always more to do and there are always lessons to be learned.

I want to thank our voluntary sector partners and our communities for all they have contributed to and supported so far. We look forward building upon the good foundations that are in place.

Being prepared for these events is incumbent on us all. Public sector organisations, our community groups, our voluntary sector groups and of course, our people, the citizens of LLR; we all have a part to play in creating, sustaining and becoming a more resilient system.

No one agency or person can do this alone so I welcome your interest in this strategy and hope that you will contribute to its delivery and its ultimate success, to empower all of us to be able to prepare, respond and recover from emergencies and disasters collectively, as one.

Kristy Ball,

Team Leader Communities Leicestershire County Council, and

Rachael Payne,

Emergency Response Officer – Leicester, Leicestershire & Rutland
British Red Cross

Co-chairs of PCOM

Working collaboratively across public services, voluntary groups and with our communities is at the heart of this Strategy and it is where we believe the biggest difference and impact can be made. We are pleased that this Strategy sets out the approach that we have been advocating and want to continue, by pro-actively supporting the delivery of all actions and activities and embedding them across LLR.

What is Community Resilience?

Community resilience can be defined as the ability of communities and individuals to harness resources and expertise to help prepare themselves for, respond to and recover from emergencies in a way that complements emergency responders.

Context

Nationally

The UK Government Resilience Framework published in December 2022 is based on three core principles:

- A **developed and shared understanding** of the civil contingencies risks we face is fundamental;
- Prevention rather than cure wherever possible: **a greater emphasis on preparation and prevention**; and
- Resilience is a **'whole of society'** endeavour, so we must be more transparent and empower everyone to make a contribution.

It is these principles, that is the focus of this Community Resilience Strategy-setting out the approach across LLR, with the aim and objectives of helping our communities to become more aware of, prepared for and resilient to emergencies and disasters such as flooding or power outages.

The government has launched the Prepare web site **https://prepare.campaign.gov.uk** to help individuals and communities nationally. This Strategy will support the national aspirations and aims through codifying our approach across LLR.

Locally

This Strategy will align with the wider work of, and be led by the Leicester, Leicestershire, and Rutland Local Resilience Forum (LRF) and Executive Board. There is ongoing work to develop and publish an LLR LRF Strategy which will be owned by the LRF Executive Board, this Community Resilience Strategy will support the relevant strategic objectives agreed by the LRF Executive Board.

Ongoing work will be overseen by the People and Communities (PCOM) Standing Group. Through developing and delivering actions within this timeframe the aim is to create a good foundation from which future actions can grow that will continue to create and support resilient communities.

The communities of LLR live and work in a blend of rural and urban areas that include people from all kinds of social, cultural, economic and religious backgrounds. This diversity affects the way emergencies impact at community, household and individual levels. The consequences of different emergencies have the potential to make people vulnerable in different ways. It is important to understand this diversity and recognise that vulnerability can be dependent on context and people are affected in different ways.

Approaches to building community resilience will need to be tailored, reflecting the characteristics of communities, their different risk environments, and local decisions about priorities. In practice, it is important community resilience initiatives reflect the diversity of the communities of Leicester, Leicestershire and Rutland and the risks which they face.

This focus on community resilience must be understood in the context of financial pressures and increasing demand on public services, including councils across LLR. Whilst all public services continue to maintain the best possible standards and services locally, the reality is that there is less money available and therefore what communities might expect to be the responsibility of, or something that can be delivered solely by 'the council' or other public service, may not now be the case.

This is why it continues to be critical that individuals and communities collaborate on activities and actions alongside public services to support and help their local areas be more prepared and resilient.

Aims

Individuals, community networks, voluntary organisations and businesses, are empowered to prepare, respond and recover from emergencies and disasters.

Public Sector and infrastructure organisations that have a responsibilities under the Civil Contingencies Act **www.legislation.gov.uk/ukpga/2004/36/contents** (Category 1 and 2 responders) understand, enable and integrate the voluntary capabilities of the public into emergency planning, response and recovery activity.

The Voluntary Sector Response Plan brings together responder voluntary organisations and encourages collaboration and improvement with those who are part of the LRF.

Objectives

Enabling resilient behaviours – informing and listening to the public about risk, appropriate preparedness and response actions, motivations and blockers to action, through pro-active and targeted actions, including:

- Response communications and alerting.
- Education awareness materials, programmes and campaigns.

Enabling community led social action – supporting community networks to understand their capabilities, access resources, tools alongside responder partners in taking collective resilience action with benefits for people and places, through:

- Facilitating and advising community networks.
- Supporting community led emergency planning.
- Facilitating access to training and physical emergency resources.

Partnering with voluntary capabilities – working with individuals, community networks, businesses, spontaneous volunteers and voluntary organisations to co-produce, design and deliver support to the public, to include:

- Convening and consulting on plans.
- Agreeing roles and activation models dependent on need and appropriate to capabilities.
- Involving voluntary capabilities in exercising

Benefits

- Individuals are proactive in enhancing their own personal and communities' resilience.
- Community networks take action to support their members to be resilient.
- Voluntary capabilities are integrated into emergency management.

Governance

This Strategy and associated Delivery Plan will be overseen by the LRF through the People and Communities Meeting, with regular reports and oversight by the LRF Executive.

Delivery Method

This Strategy advocates an approach to building community resilience which is based on the ideas of social action and community development. This means providing individuals and groups of people with the knowledge and skills they need to effect change in their own communities, through a process of engagement, education, empowerment, enablement and evaluation.

The Delivery plan that sits alongside this Strategy will be delivered using the 5 'Es'[1].

Empowerment

The LRF will work towards ensuring that individuals and communities feel empowered to take action. This may require some cultural change both on behalf of responders and communities. Communities should be aware of the risks that face them, the actions that they can take individually and collectively to prepare, respond and recover. Critically, through engagement, encouragement and education, the LRF aims to foster a culture in which individuals and communities feel they have an opportunity and responsibility to take action.

Engagement

Dialogue and engagement between responder organisations and communities is at the heart of this approach. Members of the LRF often play the role of experts, disseminating information to communities. Engagement for us, means that the approach locally will be based on listening to individual and community concerns with a focus on helping to shape and influence decisions, actions and activities collectively.

Education

Building more resilient communities as noted above, involves cultural change. While there are things that can be done in the short term, it is also a long-term project, in which learning plays a key role. Educating individuals and communities about resilience should be embedded into their everyday lives and is most effective when it connects with them and is linked to real life experiences – either emergencies which have been experienced or current news stories. The LRF will continue to develop and deliver pro-active and seasonal information and information, alongside targeted work with vulnerable groups and communities.

Enabling

The involvement of the wider voluntary and community sector is crucial to ensuring the resilience of our communities, and voluntary sector organisations will be supported to collaborate effectively and consistently with emergency the LRF including voluntary sector responder organisations.

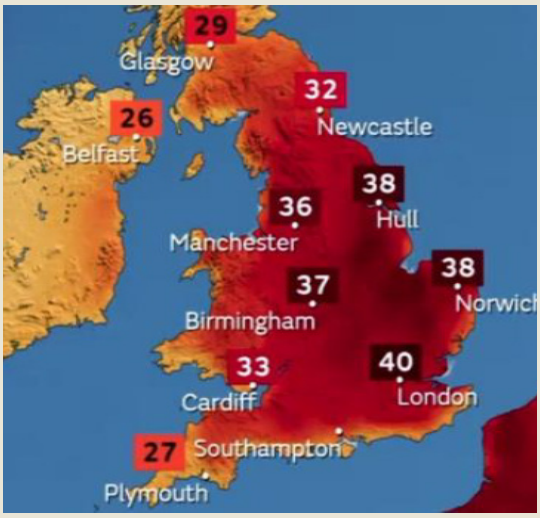
Evaluating

Resilience initiatives should be evidence-based in design, and routinely evaluated to identify best practice and key learning points, and guide future work. Good practice in evaluation is promoted with all initiatives that are developed and delivered across LLR.

1 Adapted from Building Resilient Communities, Scottish Guidance on Community Resilience, https://ready.scot/sites/default/files/2020-09/publications-preparing-scotland-building-community-resilience_.pdf

Outcomes

Increased	Reduced
Understanding of needs and ability to target support to those in the most acute need.	Social, financial and health impact from emergencies.
Public confidence and motivation to act.	Demand on emergency management resources.
Collective capability to prepare for, respond to and recover from an emergency.	Cost of response and recovery.
Trust and legitimacy of official emergency management activity.	
Speed of recovery.	



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LLR Resilience Forum
Leicester, Leicestershire and Rutland

Community Resilience Strategy 2024-2028 Delivery Plan

APPENDIX B

Objectives	Standards	Actions
Enabling resilient behaviours – informing and listening to the public about risk, appropriate preparedness and response actions, motivations and blockers to action. • Response communications and alerting. • Education awareness materials, programmes and campaigns.	A multi-agency community resilience working group of the LRF, or across multiple neighbouring LRFs, to coordinate community resilience activity. Easily accessible and regularly updated information about statutory responder and/or LRF community resilience services, resources, governance and points of contact. A communications and engagement plan to promote resilient behaviours and encourage community and voluntary networks to promote resilience and take a role in emergency management. This should use existing engagement channels and activities and have due regard to the Public Sector Equality Duty and specifically the guidance on engagement.	PCOM&R - Established working group, which meets quarterly. LLR Resilience Forum Website. https://www.llrresilienceforum.org.uk Website and Media & Comms plan. Voluntary Sector Engagement including establishing a Voluntary Sector Support Plan and Voluntary Sector Support Cell, which will be stood up alongside the SCG/TCG and other responding cells such as the Humanitarian Assistance Cell, Media and Comms Cell etc. Be aware and promote Social Media Campaigns such as 30 Days, 30 Ways each September to highlight Community Resilience and Preparedness. Volunteer Flood Wardens to receive regular information via email and quarterly newsletter.

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		District and Borough Councils, County, City and Rutland to share Resilience messages with residents via email, Social Media and other communication channels.
Enabling community led social action – supporting community networks to understand their capabilities, access resources, tools and responder partners and take collective resilience action with benefits for people and places. • Facilitating and advising community networks. • Supporting community led emergency planning. • Facilitating access to training and physical emergency resources.	Representatives from community and voluntary networks on the LRF working group. A process for identifying, mapping and regularly assessing the resilience of community and voluntary networks at highest risk to inform priorities for targeted communications and interventions.	PCOM&R need to ensure feedback/communication. Community Response Plans & the BRT project. Volunteer Community Flood Wardens are recruited, trained and regularly informed. Flood Action Groups to be encouraged to share information on specific issues LRF partners such as the Environment Agency, Lead Local Flood Authorities and the Met Office to provide Community Engagement events, training and information.
Partnering with voluntary capabilities – working with individuals, businesses, community networks, community emergency response volunteer teams, spontaneous volunteers and voluntary organisations to co-produce, design and deliver support to the public.	The community resilience considerations and the voluntary capabilities of all their member organisations integrated into existing emergency management plans.	Voluntary Sector Response Plan and the Voluntary Sector Support Cell.

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• Convening and consulting on plans. • Agreeing roles and activation models dependent on need and appropriate to capabilities. • Involving voluntary capabilities in exercising.	Identified and engaged with those community and voluntary networks which might offer support to their communities and to responders before, during or after an emergency. This includes, but is not limited to, community emergency planning groups, community emergency response teams, Parish and Town Councils, faith groups, Voluntary Community and Social Enterprise organisations.	Voluntary Sector Reasons Plan and Community Response Plans.
	A process for providing advice and support to community and voluntary networks that want to have a role in emergency management.	Voluntary Sector Response Plan and training & exercising.
	Clearly defined roles for community and voluntary networks for preparing, responding and recovering from emergencies, which are agreed and communicated prior to an incident. For example, this may range from informal expectations for neighbours to support one another to formal partnership arrangements utilising memorandums of understanding and codes of conduct.	Voluntary Sector Response plan and Community Response plans.
	A regularly updated database of local and national voluntary capabilities available to support emergency response and	

APPENDIX B

	recovery, with clear activation processes which are agreed and communicated to all partners. Locally agreed arrangements to manage spontaneous offers of support to affected people and to emergency responders in emergencies, including financial and physical donations, unaffiliated 'spontaneous' volunteers, in-kind resource and expertise.	Voluntary Sector Response Plan and the activation of the Voluntary Sector Support Cell. Community Response Plans should include hyper local groups who could provide support before, during and after an incident. Some of our Voluntary Sector agencies receive training in the Management of Spontaneous Volunteers, so could be utilised in this role.
Other	Representation of the community resilience working group on the LRF executive and on other working groups such as Risk Assessment, Warning and Informing, Business Continuity Promotion, Human Aspects, Voluntary Sector Partnerships and on relevant national groups. Community resilience approaches, programmes and lessons are proactively shared with neighbouring LRFs, national networks and through Joint Organisational Learning Online.	PCOM&R

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Overarching	A community resilience coordinator who works across the LRF partnership to coordinate community resilience activity. Defined goals, success indicators and timeframes for engagement and interventions with community and voluntary networks.	

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Leicestershire County Council

HEALTH AND WELLBEING BOARD

29 MAY 2025

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PHARMACEUTICAL NEEDS ASSESSMENT 2025:

PROGRESS REPORT AND PRE-CONSULTATION DRAFT

Purpose of Report

1. The purpose of this report is to provide the Health and Wellbeing Board (HWB) with an update on work undertaken to produce the draft Pharmaceutical Needs Assessment (PNA) 2025 and to seek the Board's approval to consult on the draft document.

Recommendation

2. The Health and Wellbeing Board is asked to:
   a. Note the work undertaken to produce the draft PNA 2025, which has been developed in line with the findings of public and pharmacy surveys;
   b. Approve the draft PNA 2025, subject to any comments the Board might have, for statutory consultation; and
   c. Note that a further report will be considered by the Board at its meeting in September 2025 detailing the outcome of the consultation and seeking approval of the final PNA 2025.

Policy Framework and Previous Decisions

3. The HWB has a statutory responsibility to prepare a PNA for Leicestershire and publish it by 1 October 2025. At its meeting on 26th of September 2024, the Health and Wellbeing Board noted the proposed timescales and process for the production of the PNA, along with its areas of focus, likely structure, governance and consultation arrangements to inform the draft.

4. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (amended) set out the minimum information that must be contained within a PNA and outline the process that must be followed in its

development and can be found at:
https://www.legislation.gov.uk/uksi/2013/349/contents

5. The last PNA for Leicestershire was produced in 2022 and can be accessed at: https://www.lsr-online.org/pna-for-2022

6. The Health and Wellbeing Board considered reports relating to the 2022 PNA on 2 February 2022 and 26 May 2022. It was intended that at the meeting in September 2022 the Board would be asked to approve the final version of the PNA but due to the passing of HM Queen Elizabeth II the September 2022 meeting was cancelled therefore approval was given by the Chief Executive using his delegated powers.

Background

7. The purpose of the PNA is to:
   - identify the pharmaceutical services currently available and assess the need for pharmaceutical services in the future.
   - inform the planning and commissioning of pharmacy services by identifying which services should be commissioned for local people, within available resources, and where these services should be.
   - inform decision making in response to applications made to NHS England by pharmacists and dispensing doctors to provide a new pharmacy. The organisation that will make these decisions is NHS England.

8. The PNA is a statutory document that is used by NHS England to agree changes to the commissioning of local pharmaceutical services. As such, if NHS England receives a legal challenge to the services they commission based on the PNA, the local authority could also be part of that legal challenge. It is essential that the process that is followed meets the legislation that is set out and that the PNA is a robust document.

9. The national guidance for developing a PNA was published by the Department of Health and Social Care in October 2021 as an information pack for local authority health and wellbeing boards. As the guidance was not updated for the 2025 PNA, the 2021 document still applies. It can be accessed via the following link: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

10. A LLR PNA Reference Group has been established to oversee the production of the 2025 PNA documents for Leicester, Leicestershire and Rutland to ensure a consistent local approach. Membership of the Group includes representatives of the local authorities, Community Pharmacy Leicestershire and Rutland, Integrated Care Board, HealthWatch, LLR Local Medical

Committee, Voluntary sector and District Councils. While ensuring a common approach across the three areas, separate PNAs for Leicester, Leicestershire and Rutland were prepared for the appropriate Boards.

11. The principal resourcing for the development of the Leicestershire PNA is provided by the Public Health Department Business Intelligence Team, with information and advice provided through the Reference Group by relevant commissioning organisations.

12. The regulations and guidance documents provide information on the PNA content. This has been reflected in the draft PNA included as **Appendix A**. Although a similar approach to that taken in the 2022 PNA has been used when developing the PNA content, there have been some variation in content and presentation, dictated by some important changes in pharmaceutical services since the last PNA.

Progress to Date

13. The PNA Reference Group considered pre-consultation drafts at its meeting on 30th April 2025, discussing their contents in light of statutory requirements. The views of the Reference Group have been incorporated into the draft Leicestershire document attached at **Appendix A**. This draft includes analysis and presentation of available data and also the headline results from the surveys of Leicestershire residents and the survey of local pharmacies. In light of the relatively low response rate to the professional survey (43 responses across LLR so far) the survey will remain open until the end of July, and the findings will be incorporated into the final PNA report. The PNA Appendices are not included, as they are lengthy documents; they are however available online (https://www.lsr-online.org/pna-for-2025).

14. The draft 2025 PNA contains a number of preliminary conclusions and recommendations drawn from emerging data and evidence on local pharmaceutical services. These will be reviewed following the statutory stakeholder engagement to take place in June-July 2025.

Consultation/Patient and Public Involvement

15. To gather additional intelligence for the development of the draft PNA, two surveys ran from February to April 2025. The public survey asked service users for their views on the current pharmaceutical provision – this survey had a good response rate (1,227 respondents across LLR, including 739 Leicestershire residents). The professional survey gathered data on services provided from pharmaceutical professionals. Because of the lower than expected response rate (43 responses across LLR), the professional survey will be left open

through the summer. The headline findings from these two survey exercises have been incorporated into the initial draft PNA document and will be updated with other results of engagement in September 2025.

16. The PNA is subject to a minimum 60-day statutory consultation period which, subject to approval, will commence in June 2025. The Pharmaceutical Services Regulations specify that the Health and Wellbeing Board must consult with the following:
    - the local pharmaceutical committee;
    - the local medical committee;
    - pharmacy and dispensing appliance contractors included in the pharmaceutical list for the area of the health and wellbeing board;
    - dispensing doctors included in the dispensing doctor list for the area of the health and wellbeing board, if any;
    - any pharmacy contractor that holds a local pharmaceutical services contract with premises that are in the health and wellbeing board's area;
    - Healthwatch, and any other patient, consumer, or community group in the area which the HWB believes has an interest in the provision of pharmaceutical services;
    - any NHS trust or NHS foundation trust in the HWB area;
    - NHS England, and;
    - any neighbouring Health and Wellbeing Board.

17. Health and Wellbeing Boards must consult the above at least once during the process of developing the PNA. Those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

18. An effective statutory consultation process is being developed. The draft PNA will be published on the Leicestershire County Council website and the views of the statutory consultees and other stakeholders will be actively sought.

Resource Implications

19. Pharmacy Services are core funded through NHS England budgets but also commissioned for extra services from a range of sources. Any changes in services and provision will impact on those particular budgets. The PNA has been developed within existing business intelligence and public health budgets, including the consultation arrangements.

Timetable for Decisions

20. The project timetable is included as **Appendix B**. The deadline for delivering an approved PNA is the 1st of October 2025. The current timescales are:

- 29 May - pre-consultation draft PNA submitted to the Health and Wellbeing Board for approval to consult;
- June – July – formal 60-day consultation;
- 25 September 2025 – final PNA submitted to the Health and Wellbeing Board for approval;
- 1 October 2025 – Publication of the PNA.

Background papers

Pharmaceutical Needs Assessment Guidance and Regulations

https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

Report considered by Health and Wellbeing Board 26 May 2022

https://democracy.leics.gov.uk/documents/s169091/Final%20PNA%20Update%20Leics%20HWBB%20May%202022.pdf

Report considered by Health and Wellbeing Board 1 December 2022

https://democracy.leics.gov.uk/documents/s172370/Urgent%20action%20taken%20by%20the%20Chief%20Executive.pdf

Circulation under the Local Issues Alert Procedure

None

Appendices

Appendix A – Pre-consultation Draft of the 2025 Leicestershire PNA

Appendix B – LLR 2025 PNA Project Timeline

Appendix C – Draft of the Appendix to the 2025 Leicestershire PNA (online only - https://www.lsr-online.org/pna-for-2025)

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Relevant Impact Assessments

Equality and Human Rights Implications

21. The PNA will be subject to an Equality Impact Assessment. The consultation process has sought to obtain and analyse views from the wide range of equalities groups.

Partnership Working and associated issues

22. The PNA has been produced in partnership with a range of partner agencies who have an interest in continued effective and efficient delivery of pharmacy services in the county and related services.

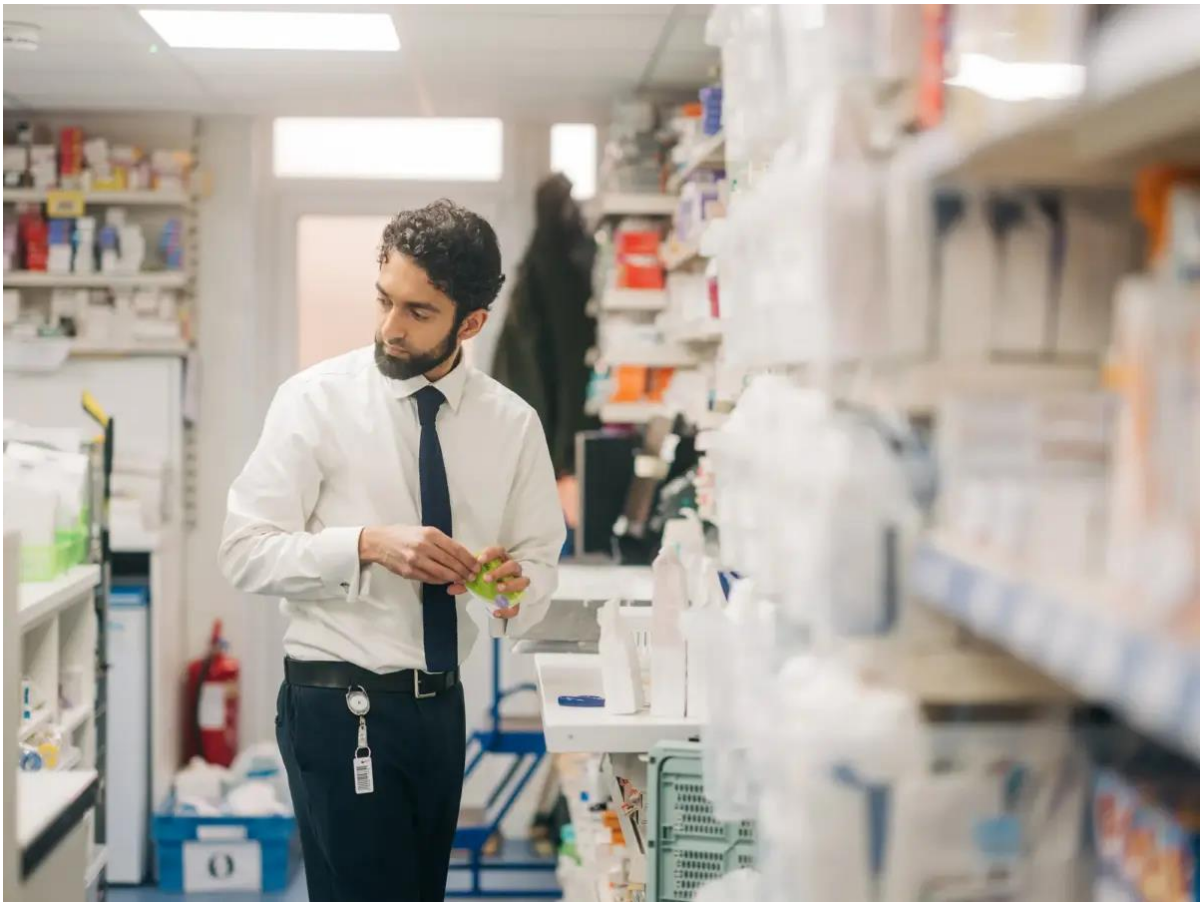
Risk Assessment

23. The assessment looks at a wide range of factors related to the adequacy of current pharmacy services in the County and the implications and risks that would arise with inadequate provision.

APPENDIX A

Leicestershire County Council

Leicestershire Pharmaceutical Needs Assessment 2025



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Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omissions relating to the data contained within the report.

Foreword and Executive Summary

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1. Introduction

1.1. Background

The purpose of the Pharmaceutical Needs Assessment (PNA) is to identify the pharmaceutical services currently available and assess the need for these services in the future. It is a crucial part of the market entry system and supports commissioning decisions based on patient needs.

All Health and Wellbeing Boards (HWBs) must prepare PNAs to national comparable standards every three years, with the ability to issue supplementary statements in response to any interim changes relevant to the granting of applications. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs.

PNAs aim to inform the planning and commissioning of pharmacy services by identifying which services should be commissioned for the local population, within available resources, where these services should be, and inform decision making by NHS England and Improvement in response to applications made by pharmacists and dispensing doctors to provide a new pharmacy.

This edition of the Leicestershire PNA reviews pharmacy coverage (excluding internet pharmacies) and dispensing GPs in relation to the health needs of the people of Leicestershire. This includes looking at the existing services, their locations, the breadth of services they are providing and the views of the people that are using them.

The Health and Social Care Act 2012 established Health and Wellbeing Boards. From April 2013, Health and Wellbeing Boards became responsible for developing and updating pharmaceutical needs assessments. At the same time responsibility for using pharmaceutical needs assessments as the basis for determining market entry to a pharmaceutical list transferred from primary care trusts to NHS England and NHS Improvement. Both HWBs and Local Pharmaceutical Committees (LPCs) were issued with appropriate national guidance on how to prepare and use PNAs in their localities.

If a person (a pharmacist, a dispenser of appliances or a GP) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and are held by NHS England and NHS Improvement. This is commonly known as the NHS “market entry” system.

In order to be included on a relevant pharmaceutical list, the applicant applies by proving they are able to meet a pharmaceutical need as set out in the relevant Pharmaceutical Needs Assessment (PNA). There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only)

basis.

The latest PNA for Leicestershire was produced in 2022 by the Leicestershire Health and Wellbeing Board. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 requires all Health and Wellbeing Boards to publish a revised assessment within three years of publication of their first assessment. This PNA replaces the 2022 document.

The national guidance recommends basing recommendations on service data for the latest available financial year, which would mean the services that were provided on the 31st of March 2024. However, the fast-moving changes in provision in more recent months, particularly for clinical services, dictated a further analysis of services and trends in their provision up to the end of December 2024, with clear indication where data are of a provisional nature.

1.2. Purpose of the PNA

The Pharmaceutical Needs Assessment is the key local tool for understanding the provision of pharmaceutical services in a local area as well as identifying and assessing which pharmaceutical services need to be provided by local community pharmacies and other providers in the future. It informs local commissioning decisions by NHS England, Integrated Care Boards and local authorities by identifying which pharmaceutical services should be commissioned within available resources, and their location.

PNA must be aligned to other relevant local assessments and plans for health and social care, such as the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy. It should also examine population demographics and available services in neighbouring areas that may affect local service need.

A key role of a PNA is to identify gaps in pharmaceutical service provision and inform decision making in response to applications made to NHS England by organisations to provide a new pharmacy.

National regulations require that a number of statements are contained within a PNA:

1. A statement of pharmaceutical services that the Health and Wellbeing Board has identified as services that are necessary to meet the need for pharmaceutical services.
2. A statement of pharmaceutical services that have been identified as services that are not provided but which the Health and Wellbeing Board is satisfied need to be provided in order to meet a current or future need for a range of pharmaceutical services or a specific pharmaceutical service.
3. A statement of pharmaceutical services that the Health and Wellbeing Board has

identified as not being necessary to meet the need for pharmaceutical services but have secured improvements or better access.

4. A statement of the pharmaceutical services that have been identified as services that would secure improvements or better access to a range of pharmaceutical services or a specific pharmaceutical service, either now or in the future.
5. Other NHS services that affect the need for pharmaceutical services or a specific pharmaceutical service.

Information that will be included or considered within the PNA includes:

- How the Health and Wellbeing Board has determined the localities in its area.
- How it has taken into account the different needs of the different localities, and the different needs of those who share a protected characteristic.
- A report on the consultation.
- A map that identifies the premises at which pharmaceutical services are provided.
- Information on the demography of the area.
- Whether there is sufficient choice with regard to obtaining pharmaceutical services.
- Any different needs of the different localities; and
- The provision of pharmaceutical services in neighbouring Health and Wellbeing Board areas.

A number of added services have changed the way community pharmacies are perceived and relied upon. Pharmacies remained open during the height of the COVID-19 pandemic, enabling patients to access clinical expertise without an appointment. The more recent years have seen a fast development of clinical services provided by local pharmacies. This PNA seeks to build on the new emerging role of pharmacies in the local community.

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2. Pharmaceutical Services and Pharmacy Contractors

2.1. Services

2.1.1. The Pharmacy Contract

Under the Community Pharmacy Contractual Framework (CPCF) there are three tiers of community pharmacy services (the 'pharmacy contract'):

1. **Essential services** – core services that all pharmacies must provide, including dispensing (and repeat dispensing) of medicines and appliances, disposal of unwanted medicines, promotion of healthy lifestyles, signposting or support for self-care. The Discharge Medicines Service (DMS) is one of the essential services since 2021.
2. **Advanced services** – these are optional services that pharmacies may choose to provide under contract, examples include appliance use reviews (AUR), flu vaccinations, hypertension case-finding, Pharmacy First, pharmacy contraception service (PCS) or smoking cessation services (SCS).
3. **Enhanced services** – the third tier of pharmacy contract includes services which can be designed nationally (National Enhanced Service or NES) or locally (Local Enhanced Service or LES). The former is nationally specified and commissioned by NHS England, while the latter is designed locally, with input from the Local Pharmaceutical Committee. NES does allow for some flexibility in the local commissioning of the service, but conditions are standardised nationally.

2.1.2. Locally Commissioned Services

In addition to the three tiers of services described above, pharmacies can be commissioned locally, usually by the NHS or local authority, to provide services tailored to meet the specific needs of the local population. Examples include emergency hormonal contraception (EHC), needle and syringe exchange, supervised administration of methadone and other opioid substitutes or the take home naloxone programme.

Alongside services commissioned by the NHS and other public bodies they may also provide **private services** – services not commissioned by public bodies, e.g., travel health advice.

Further details of the current pharmacy services, including pharmacy contract tiers and locally commissioned services, are given in the Section 6, page 39.

There are four types of community pharmacy contractors:

1. **Community Pharmacies** – standard contract, those on a **pharmaceutical list** – healthcare professionals working for themselves or employees. They practice in

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pharmacy (the field of health sciences focusing on safe and effective medicines use).

2. **Dispensing Appliance Contractors (DAC's)** – only dispense prescriptions for appliances, not medicines. Contracted to the NHS, these businesses dispense appliances listed in the Drug Tariff against prescriptions issued by GPs and specialist nurse prescribers. DACs operate nationally and supply the appliances directly to patient's homes. They provide essential services (dispensing, repeat dispensing, home delivery, urgent supply without prescription and signposting (product supply) and may opt to provide advanced services such as stoma customisation or appliance use review (AUR).
3. **Dispensing GPs** – GP practices can dispense medicines to patients who live more than 1.6 km away from a pharmacy (further details in 'Error! Reference source not found.').
4. **Local Pharmaceutical Service (LPS) contract** – allows NHS England to commission community pharmaceutical services tailed for the local needs. It provides more flexibility within the locally negotiated contract for a narrower or wider set of services, according to local requirements.
5. **Distance Selling Pharmacies (DSPs)** are able to provide the full range of essential, advanced and enhanced services to the population, without face-to-face contact. A DSP receives prescriptions either via the electronic prescription service or through the post, dispenses them at the pharmacy and then either delivers them to the patient or arranges for them to be delivered using a courier. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 detail a number of conditions for distance selling pharmacies (DSPs) in addition to the regulations governing all pharmacies. Thus, DSPs must provide Essential Services to anyone, anywhere in England, when requested to do so. They may choose to provide Advanced or Enhanced Services, but when doing so must ensure that they do not provide any element of the Essential Services whilst the patient is at the pharmacy premises. Since October 2021, DSPs may choose, but are not required, to install a consultation room at their pharmacy to allow the provision of Enhanced and Advanced Services on the premises. However, they must ensure that there are arrangements in place at the pharmacy which enable staff and patients to communicate confidentially remotely, by telephone or another live audio link, and a live video link. DSPs must have a website for patients and the public accessing their services to use, with an interactive page that is clearly promoted when they first access the website, and with a reasonable range of up-to-date materials that promote healthy lifestyles, by addressing a reasonable range of health issues.

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2.2. Services Excluded from this PNA

The PNA is set out by regulation to cover the services described in Section 2 above.

Other providers of pharmaceutical services in Leicestershire, not included in this report, are prison pharmacies and hospital pharmacies.

2.2.1. Prison Pharmacy

In Leicestershire, pharmaceutical services are provided in HMP Gartree, a category B men's prison located in Market Harborough. Health services provided within prisons require a pharmaceutical service to support the delivery of healthcare and the supply of medicines. The unique nature of the environment and the predominance of certain clinical services in some prisons, such as substance misuse services, means that these services are provided by contracted providers with a model that is determined to support the prison population safely.

2.2.2. Hospital Pharmacy

Around 20% of pharmacists work in hospitals and play an essential role in patient care. In Leicestershire, patients access acute care from a range of hospital providers (University Hospitals of Leicester NHS Trust, Community hospitals in Coalville, Hinckley, Loughborough, Lutterworth, Melton and Market Harborough and out of county providers). Whilst in hospital, patients' medicines are dispensed and managed by hospital pharmacists. A hospital pharmacy is a specialized pharmacy department, which prepares, compounds, stocks, and dispenses inpatient medications, often including specialized and investigational drugs not found in community pharmacies.

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3. Process of Developing the PNA

The Health and Wellbeing Board has a statutory responsibility to prepare a Pharmaceutical Needs Assessment (PNA) for Leicestershire every three years, this edition's completion date being the 1 October 2025.

The Board has tasked the Leicester, Leicestershire and Rutland (LLR) PNA Reference Group to oversee and develop the draft PNA on their behalf.

The inter-agency PNA Reference Group was established because many of the relationships required for the PNA were Leicester, Leicestershire and Rutland (LLR) wide. The group included representation from the local NHS (LLR Integrated Care Board), HealthWatch, East Midlands Primary Care Team, LLR Local Medical Committee, Voluntary Action LeicesterShire, Leicestershire Equalities Challenge Group, as well LLR County and District Councils. The group's terms of reference are attached as Appendix A.

The PNA was subject to a 60-day statutory consultation period running from June to August 2025. Regulation 8 of the Pharmaceutical Services Regulations specifies that the Health and Wellbeing Board must consult with the following:

- Local Pharmaceutical Committee
- Local Medical Committee
- Integrated Care Board (LLR ICB)
- persons on the pharmaceutical lists and any dispensing doctors list for its area
- LPS chemist in its area with whom NHS England and NHS Improvement has made arrangements for the provision of any local pharmaceutical services
- HealthWatch and any other patient, consumer or community group in its area which in the view of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area
- NHS trust or NHS foundation trust in its area
- any neighbouring Health and Wellbeing Board

The full range of statutory bodies required were contacted and asked to participate in the consultation. In addition, the consultation was distributed and promoted to other groups likely to be interested. The results are set out later in this report.

Furthermore, through two surveys taking place through February, March and early April 2025, a consultation took place with local pharmaceutical professionals and service users to gather evidence to support the PNA.

4. Health Needs of the Leicestershire Population

Although the most pertinent information to the PNA is included in this chapter, there are additional reports available to further enrich the evidence base for the health and wellbeing of the population, including Leicestershire's Joint Strategic Needs Assessment (JSNA) for 2022-2025, the Leicestershire Joint Health and Wellbeing Strategy 2022-2032[2], the Public Health Outcomes Framework (PHOF) report published for Leicestershire County Council[3], district profiles[4] and the Director of Public Health's Annual Reports.

These reports can be found here: https://www.lsr-online.org/health-and-wellbeing-leicestershire3

4.1. Population

The latest (2023) population estimates show that, compared to England and the East Midlands Region, Leicestershire has a higher percentage of people aged 65 years or more (Table 1). In Leicestershire, 21% of the population is aged 65 or over, compared to 18.7% across England. The ratio of those over 65 to the 16-64 age group is 34.1, compared to 29.7 for England ('old age dependency ratio' or OADR[1]). With changing patterns of retirement age OADR is becoming less useful as an economic measure but is serving here as a broad indicator of population age structure.

Table 1. Broad age group population comparison between Leicestershire, East Midlands and England (mid-2023 population estimates, ONS 2024)

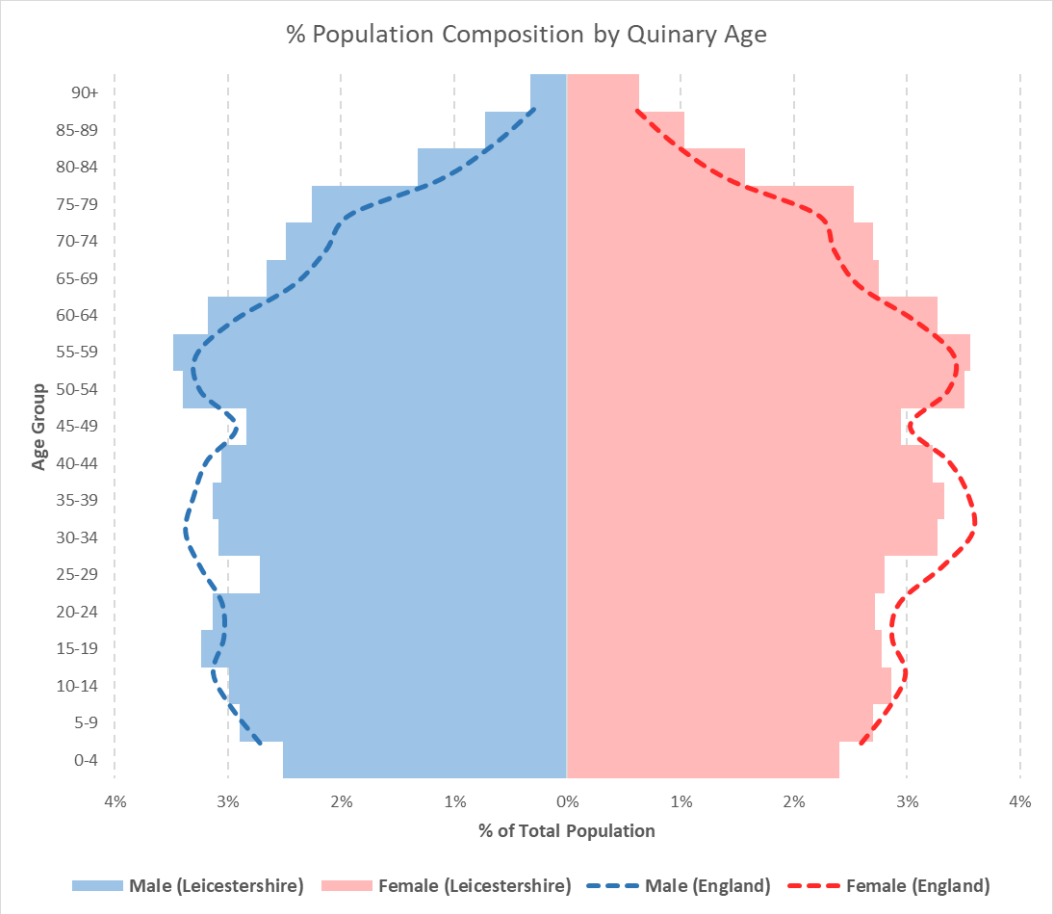
Area	0-15		16-64		65-79		80+		Total	OADR
	No*	%	No*	%	No*	%	No*	%		
England	10,648	18.5%	36,259	62.9%	7,860	13.6%	2,923	5.1%	57,690	29.7
East Midlands	901	18.1%	3,103	62.2%	727	14.6%	260	5.2%	4,991	31.8
Blaby	19.8	18.8%	63.7	60.5%	15.8	15.0%	5.9	5.6%	105	34.1
Charnwood	31.4	16.7%	120.7	64.2%	26.3	14.0%	9.6	5.1%	188	29.8
Harborough	18.0	17.5%	61.8	60.2%	16.6	16.2%	6.3	6.1%	103	37.0
Hinckley & Bosworth	19.9	17.3%	68.9	60.0%	19.3	16.8%	6.8	5.9%	115	37.9
Melton	9.0	16.9%	31.4	58.9%	9.6	18.0%	3.3	6.2%	53	41.0
North West Leicestershire	19.5	17.7%	68.8	62.3%	16.7	15.2%	5.3	4.8%	110	32.1
Oadby and Wigston	11.1	18.7%	36.1	60.5%	8.6	14.4%	3.8	6.4%	60	34.4
Leicestershire	128.7	16.4%	460.0	62.7%	113.0	15.4%	41.0	5.6%	734	**34.1**

* In thousands

[1] Number of individuals aged 65 and over per 100 people of working age

Leicestershire has proportionately more residents in older age groups, when compared to England. Conversely, there are less children and younger adults (Figure 1).

Figure 1. Age structure of the Leicestershire population - mid-2023 estimates



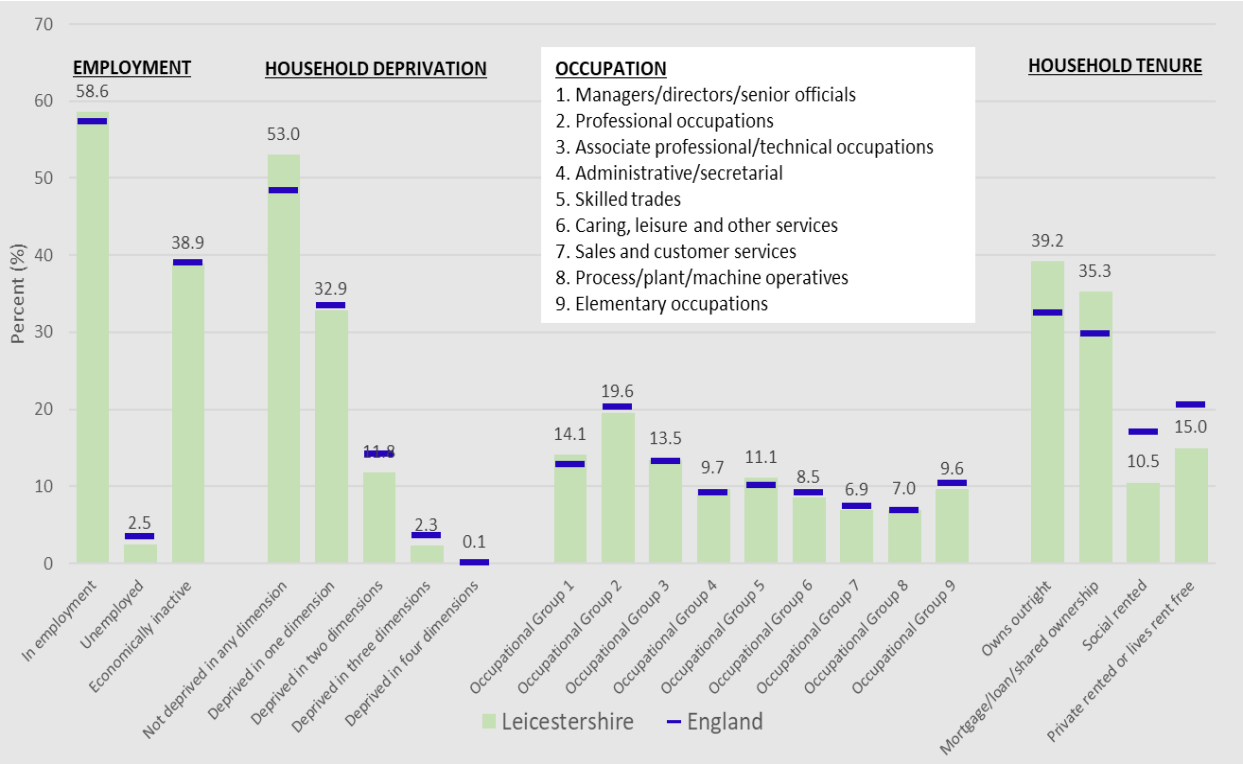
Source: Office for National Statistics 2024

4.2. Socio-Economic Deprivation

4.2.1. Census 2021

The broad socio-economic profile of the Leicestershire population, based on Census 2021, shows a higher proportion of households as not deprived in any dimension (53% vs 48% nationally), and less of those deprived in two or more dimensions. Also, a higher proportion of the Leicestershire population owned their homes outright or through mortgage or loan, with lower than national average rates of social or private renting (household tenure). Other indicators show broadly similar patterns to the national average (Figure 2).

Figure 2 Summary of socio-economic indicators from Census 2021



Source: Office for National Statistics 2023

4.2.2. Index of Multiple Deprivation

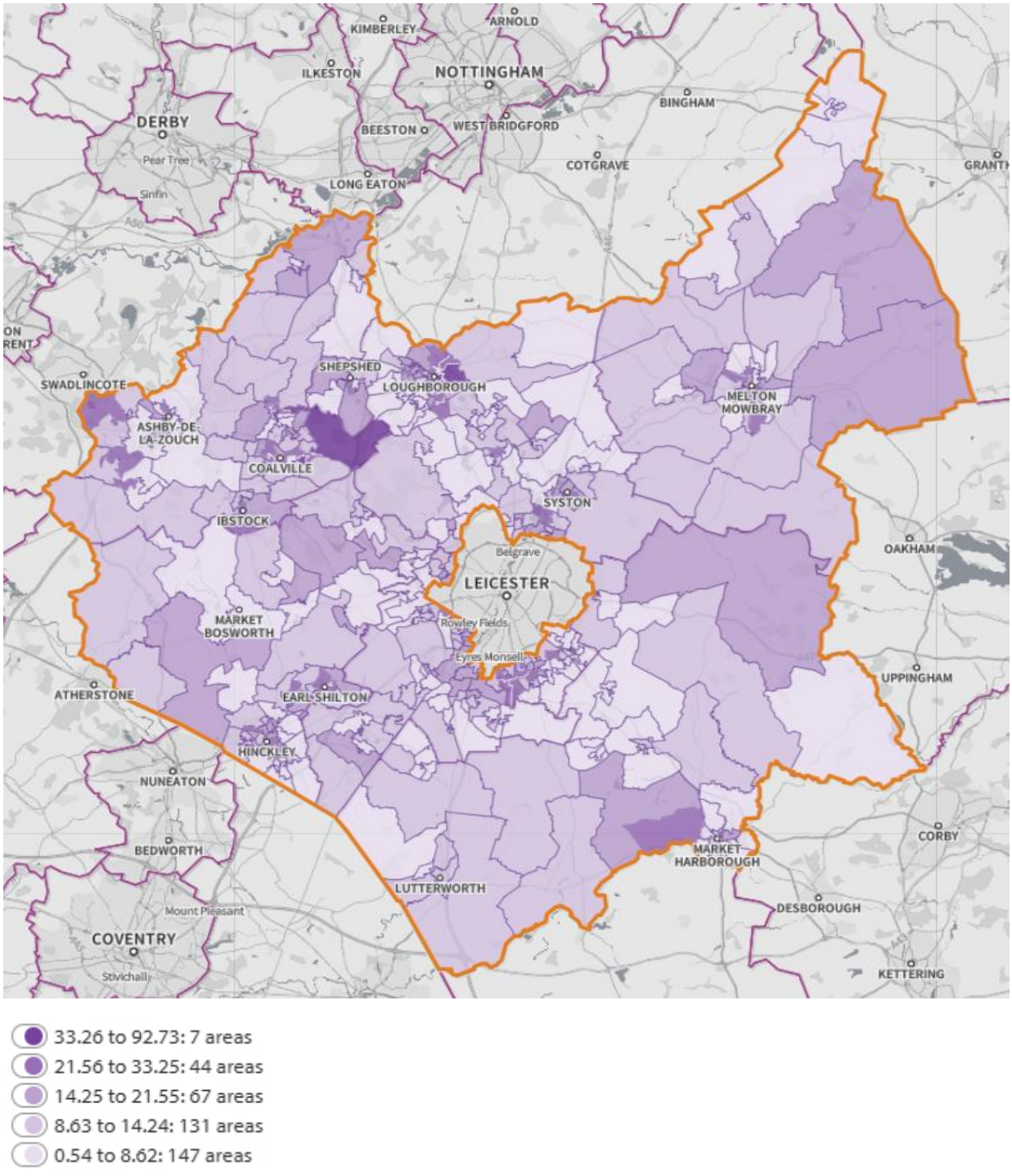
The indices of deprivation use several measures in each of seven "domains":

- Income deprivation, including Income deprivation affecting children (IDACI) and Income deprivation affecting older people (IDAOPI)
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services
- Crime
- Living environment deprivation.

The average levels of deprivation across Leicestershire measured by the Indices of Multiple Deprivation (IoD)5 are not high when compared to the national figures, but there are pockets of deprivation across the county particularly in North West Leicestershire and Charnwood. Although a useful measure at a larger scale, IoD is known to be biased towards urban deprivation. As a large proportion of Leicestershire is rural in character, it has specific issues expressed better through the Barriers to Housing and Services domain of the IoD. Within this domain predominantly rural areas show significant problems rooted in poor access to housing

and services. Overall, the socio-economic deprivation is relatively low in Leicestershire, with pockets of deprivation in North West Leicestershire (3.5% of LSOAs classified within worst national decile) and Charnwood (2% of LSOAs highly disadvantaged); 7 of the Leicestershire LSOAs are in the worst national quintile (Figure 3).

Figure 3 IMD 2019 by national quintile



In summary:

- 2% of the population of Leicestershire (11,642) people live in areas categorised within the most deprived 20% (decile 1 and 2) of areas in the country.
- Three districts in Leicestershire; Charnwood, Hinckley and Bosworth and North-West Leicestershire, have areas which are in the most deprived 20% in the country.
- 11% of the Leicestershire population live in deciles 3 and 4 of deprivation (in the most deprived 20-40% of areas in England), accounting for over 76,000 people. All seven districts have people in this category of deprivation.
- Over two-thirds (71%) of the population of Leicestershire live in the least 20% deprived (deciles 9 and 10) and least 20-40% deprived areas in England.

However, consistent with their rural character, many areas in Leicestershire have problems with housing and access to services (Figure 4). Within Melton, 20% of all LSOAs fall within the worst national decile for this domain, 17% of Harborough LSOAS and 6% of those within Hinckley and Bosworth District.

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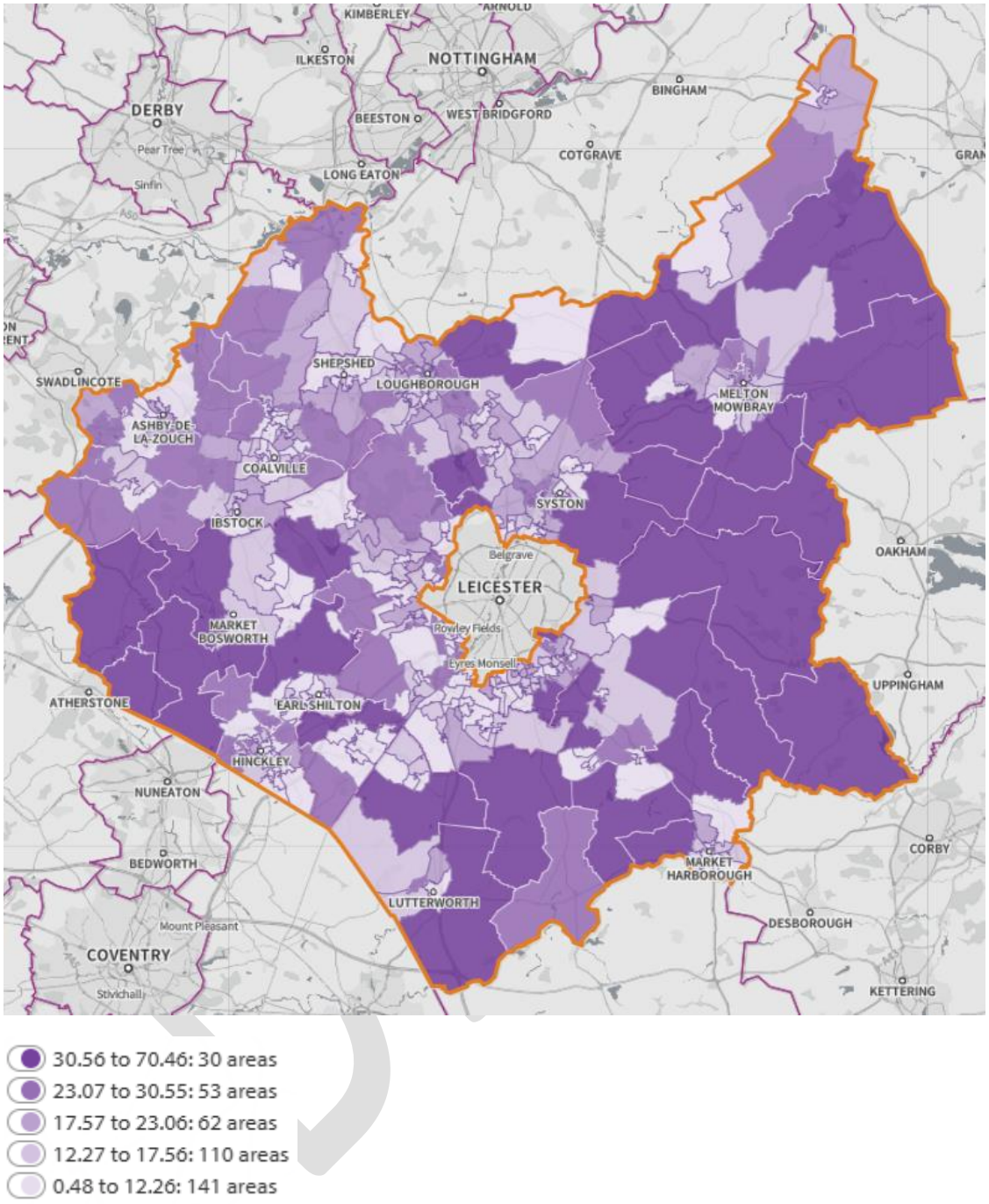
Figure 4 IMD 2019 - Barriers to Housing and Services domain only, by national quintile



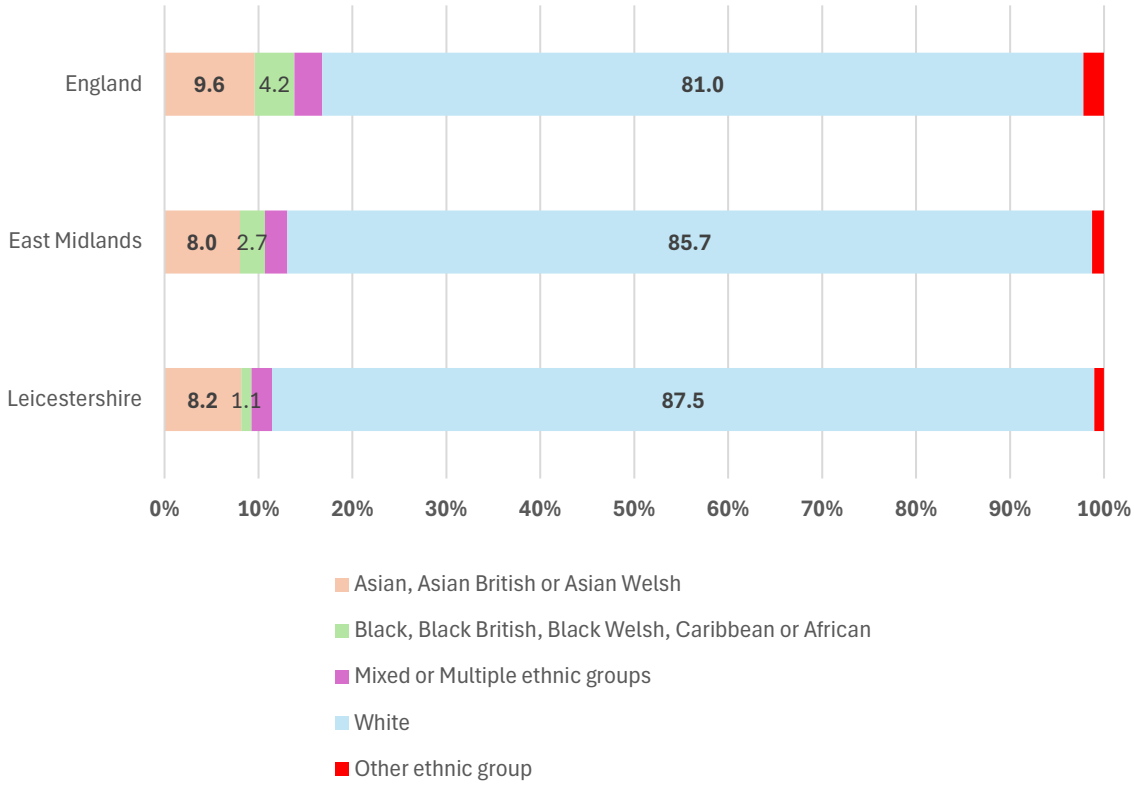
4.3. Ethnicity

In 2021, the largest proportion (87.5%, N=632,426) of the Leicestershire population was of a white[2] ethnic background which is significantly more than the average for England (81%) (Figure

[2] Includes the following categories – white English/Welsh/Scottish/Northern Irish/British, Irish and other white

5). The total number in other ethnic groups was 88,938, with the proportion of Asian[3] population (8.2%), followed by mixed groups (2.2%), black[4] (1.1%) and other population groups (1%). In the decade since 2011 the size of the ethnic minority population of Leicestershire has increased from 55,722 to 88,938 (a 60% rise).

Figure 5 Ethnicity of Leicestershire population (Census 2021)



Source: NOMIS, Census 2021

The picture varies across Leicestershire districts with the lowest ethnic minority proportion in Melton (3.1%) and highest in Oadby and Wigston (36.6%) (Table 2).

[3] Includes Asian or Asian British groups – Bangladeshi, Chinese, Indian, Pakistani or other
[4] Includes black and black British, African, Caribbean and other black groups

Table 2 Ethnicity of Leicestershire districts' populations (Census 2021)

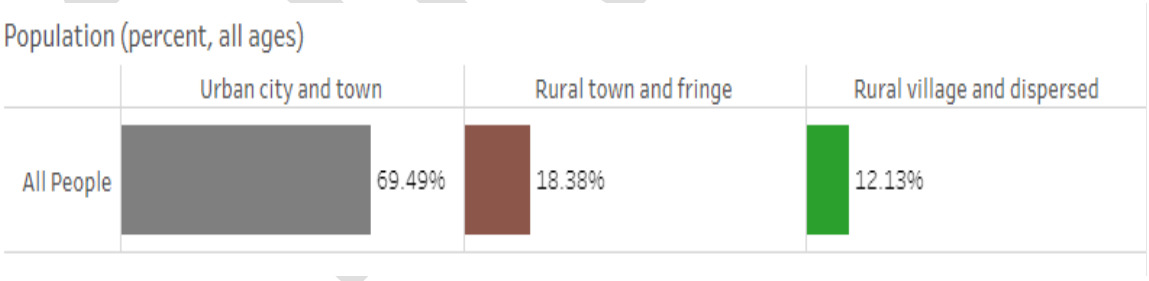
	Asian	Black	Mixed or Multiple	White	Other
Blaby	8.3	1.5	2.7	86.2	1.3
Charnwood	12.4	1.5	2.5	82.3	1.2
Harborough	5.4	0.7	2.1	91.0	0.8
Hinckley and Bosworth	2.8	0.6	1.8	94.3	0.6
Melton	1.2	0.4	1.3	96.9	0.3
North West Leicestershire	1.5	0.6	1.5	95.9	0.5
Oadby and Wigston	27.9	2.2	3.2	63.4	3.3
Leicestershire	**8.2**	**1.1**	**2.2**	**87.5**	**1.0**
England	**9.6**	**4.2**	**3.0**	**81.0**	**2.2**

Source: ONS

4.4. Rurality

According to data from Census 2011[6] , more than a third of the Leicestershire population lived in areas classified as rural ('town and fringe' 18.4% and 'village and dispersed' 12.1%), with the remaining 69.5% residing in 'urban city and town' areas (Figure 6). This profile is defined as 'urban with significant rural' component. Some of the issues affecting the health and wellbeing of rural communities include low-paid work, unemployment of young people, high costs of housing and fuel poverty, poor access to health services and lack of public transport.

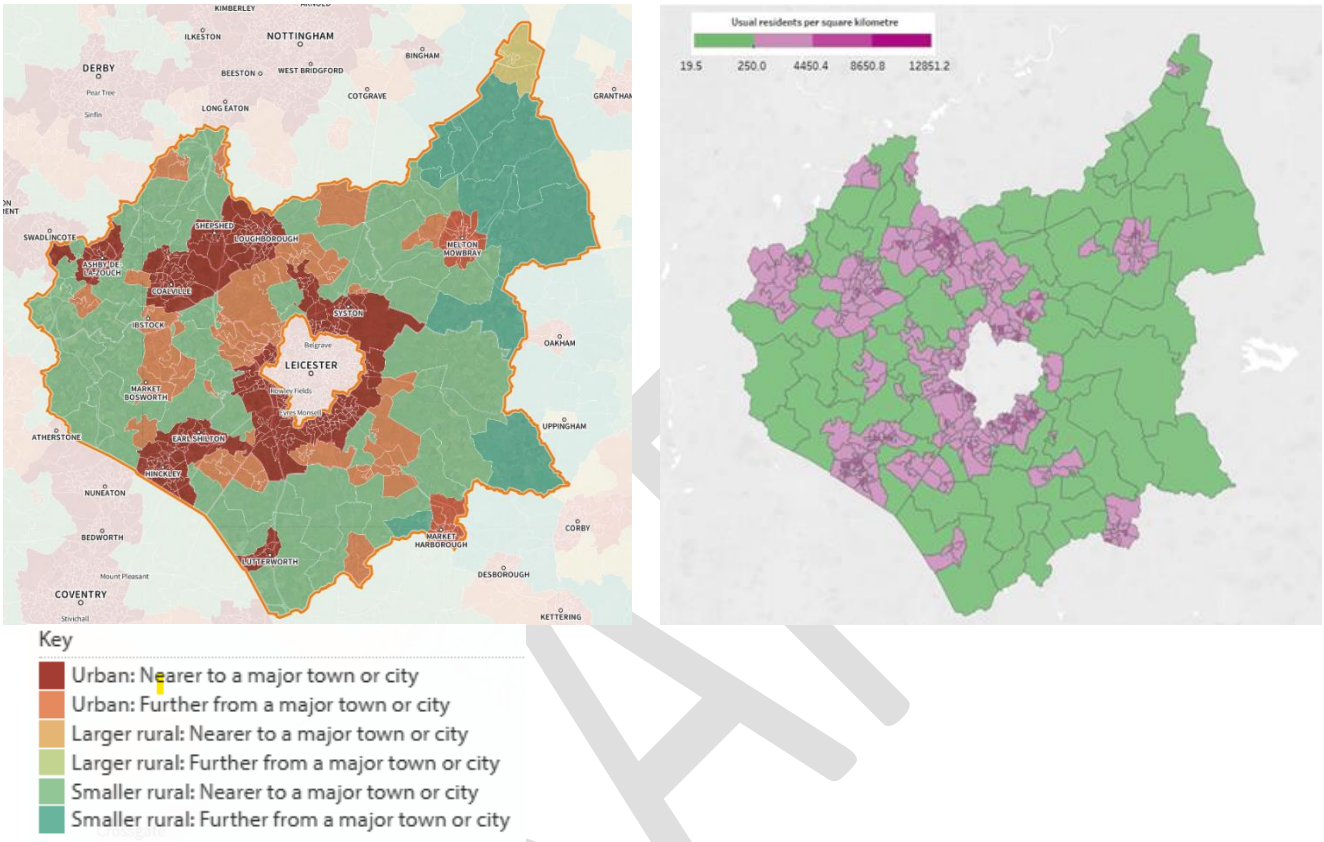
Figure 6. Population by rural-urban classification (Census 2011)



Awaiting the updated urban-rural classification for resident population, Figure 7 presents the Census 2021 population density, for comparison. The rural-urban classification relies on geographical data, namely the relationship between the built-up areas and the lowest census geographical units (Output Area or OA), assigning OAs either to the urban or the rural domain then classifying higher geographical levels (Lower SOAs, Middle SOAs and Local Authorities) using the mix of their component OAs. Population density, on the other hand, is simply the

number of usual residents in 2021 per square kilometre in the given LSOA.

Figure 7. Census 2021-based rural-urban classification (left) and population density (right) in Leicestershire



Source: ONS 2025

A detailed report on the demography of Leicestershire population can be found here: https://www.lsr-online.org/uploads/demography-2024.pdf?v=1727078295

4.5. Current Health Needs

4.5.1. Health Profiles

As part of the Public Health Outcomes Framework, health profiles are updated on a quarterly basis by the Office for Health Improvement and Disparities (OHID) and provide a useful summary of the health needs of the local population[7]. The health profiles for Leicestershire and the constituent districts are included in the Appendix. The key findings are summarised in this section (Table 3).

The health of people in Leicestershire is generally better than the England average. Leicestershire's deprivation score (12.3) is lower than the national average (21.7), however

about 16.8% children live in relatively low-income families (between 11.6% in Harborough and 18.4% in Oadby and Wigston).

For **children and young people** there are a couple of areas for improvement. A higher than average proportion of women (by 2%) smoke at the time of delivery in Charnwood, Hinckley and Bosworth and North West Leicestershire, although the average for Leicestershire is not significantly higher than the national rate. Leicestershire also has lower rates of first breast feeding (by 5%), with four of out seven districts with significantly low rates.

Leicestershire has higher rates of **adult overweight and obesity** (66% vs 64% nationally), which are relatively high in North West Leicestershire (over 71%) and Melton (just under 70%).

Among the indicators of **disease and poor health** of note are significantly lower than average rates of early cancer diagnosis in Charnwood (8% below the national average) and Oadby and Wigston (11% below the national average). The rates of admission for intentional self-harm are higher than the national average in all but one district (Oadby and Wigston). In addition, the rate of alcohol-related admissions is higher than expected in North West Leicestershire (by 20%).

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Table 3 Health Profile Summary for Leicestershire and constituent Districts. Source: Office for Health Improvement and Disparities 2025

		England	Leicestershire	Blaby	Charnwood	Harborough	Hinckley & Bosworth	Melton	NW Leicestershire	Oadby & Wigston
Our Communities										
1	Deprivation score (IMD 2019)	21.7	12.3	10.6	13.2	8.0	13.5	12.5	14.6	13.0
2	Children in relative low-income families (under 16s)	19.8	16.8	15.8	18.1	11.6	17.7	18.1	17.7	18.4
3	Homelessness: households owed a duty under the HRA	12.4	6.8	9.6	*	6.3	9.4	14.6	7.0	11.7
4	Average Attainment 8 score	46.2	46.3	44.9	47.7	48.6	46.6	47.4	41.4	48.2
5	Violent crime*	34.3	17.1	15.5	14.7	15.0	22.5	16.2	20.7	17.7
6	Percentage of people in employment	75.7	81.5	84.7	81.0	78.9	82.6	74.4	83.1	83.3
Children and Young People										
7	Smoking status at time of delivery	7.4	8.0	6.8	9.1	6.7	9.4	6.4	9.4	6.4
8	Baby's first feed breastmilk	71.9	66.5	69.4	66.0	70.6	64.3	65.3	61.4	70.5
9	Year 6 prevalence of obesity (including severe obesity)	22.1	18.6	18.9	18.3	15.8	17.8	19.0	20.7	20.7
10	Admission episodes for alcohol-specific conditions (<18s)	26.0	13.0	*	9.6	17.0	15.0	*	15.9	*
11	Under 18s conception rate / 1,000	13.1	10.7	11.0	9.6	5.2	14.0	10.7	15.5	9.0
Adults and Lifestyle										
12	Smoking Prevalence in adults (aged 18+) - current smokers	11.6	9.5	11.2	6.2	9.9	8.9	9.6	9.9	17.4
13	Percentage of physically active adults	67.1	70.1	66.1	74.0	67.9	75.4	64.8	71.4	59.6
14	Overweight (including obesity) prevalence in adults	64.0	65.9	66.5	61.5	60.7	66.8	69.8	71.2	65.3
Disease and Poor Health										
15	Percentage of cancers diagnosed at stages 1 and 2	54.4	52.6	54.3	46.7	57.3	55.2	59.0	52.5	43.5
16	Emergency Hospital Admissions for Intentional Self-Harm	126	169	167	183	162	174	194	169	122
17	Admission episodes for alcohol-related conditions	475	467	437	468	453	419	509	568	423
18	QOF diabetes registration (%)	7.7	7.8	*	*	*	*	*	*	*
19	TB incidence (three year average)	7.6	4.1	5.5	5.2	2.7	2.4	3.9	2.2	8.7
20	New STI diagnoses (exc. Chlamydia < 25) per 100,000	520	304	317	357	290	259	238	304	291
21	Hip fractures in people aged 65 and over	558	566	530	536	531	643	585	539	619
Life Expectancy and Mortality										
22	Life expectancy at birth (male)	79.3	80.4	80.8	79.4	81.0	80.5	80.0	81.0	80.7
23	Life expectancy at birth (female)	83.2	83.7	84.2	84.2	84.0	83.0	83.2	83.0	84.0
24	Infant mortality rate	3.9	3.2	3.8	3.8	1.9	3.2	4.5	2.0	3.2
25	KSI casualties on England's roads	91.9	54.8	*	*	*	*	*	*	*
26	Suicide rate	10.7	10.3	9.9	10.0	12.1	10.0	13.5	9.1	9.0
27	Smoking attributable mortality	202	172	*	*	*	*	*	*	*
28	Under 75 mortality from cardiovascular disease	77.4	65.6	58.6	60.4	67.9	65.8	64.6	78.2	65.7
29	Under 75 mortality from cancer	121	110	93	115	116	122	89	120	97
30	Winter mortality index	8.1	8.6	10.8	9.0	7.0	15.8	-1.0	4.0	9.8

Significantly better than national average

Not significantly different

Significantly worse than national average

Not RAG-rated

HRA = Homelessness Reduction Act

IMD = Index of Multiple Deprivation

* Hospital admissions for violence (inc. sexual violence)

KSI = Killed and seriously injured

4.5.2. Lifestyle Factors

Table 4 presents selected indicators from the health improvement domain of the Public Health Outcomes Framework published for local authorities[8].

As mentioned in the section above ('Health Profiles'), adult obesity in Leicestershire is significantly higher than the national average – in 2022/23 it was just under 66% against 64% in England.

Smoking and alcohol-related indicators are not significantly different to the national average, albeit the rates in 2022/23 were somewhat lower in Leicestershire.

Although the prevalence of overweight and obesity in children is significantly lower than the national rate, both at reception year and year 6 (by around 3%), year 6 prevalence is showing an upward trend in Leicestershire.

Both the happiness and anxiety scores in Leicestershire are similar to the national average.

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Table 4 Lifestyle Statistics for Leicestershire

Indicator	Time Period	Leicestershire		England	
Smoking Prevalence in adults (18+) – current smokers (APS) (2020 definition)	2023	9.5%	→	11.6%	→
Admission episodes for alcohol-related conditions (Narrow): (Persons) / 100,000	2022/23	467	→	475	→
Overweight (including obesity) prevalence in adults (18+)	2022/23	65.9%	-	64.0%	-
Reception: Prevalence of overweight (including obesity)	2023/24	19.9%	→	22.1%	↓
Year 6: Prevalence of overweight (including obesity)	2023/24	32.5%	↑	35.8%	→
Percentage of physically inactive adults (19+)	2019/20	18.9%	-	22.6%	-
Self-reported wellbeing – people with a low happiness score	2022/23	8.8%	-	8.9%	-
Self-reported wellbeing – people with a high anxiety score	2022/23	23.6%	-	23.3%	-

Source: Office for Health Improvement and Disparities: Public health profiles. © Crown copyright 2025 https://fingertips.phe.org.uk/

Recent Trend:

↑ increasing (getting worse)
↓ decreasing (getting better)
→ no significant change
\- cannot be calculated

Local Rate:

Statistically significantly better than national average
Statistically similar to the national average
Statistically significantly worse than national average

4.5.3. Life Expectancy

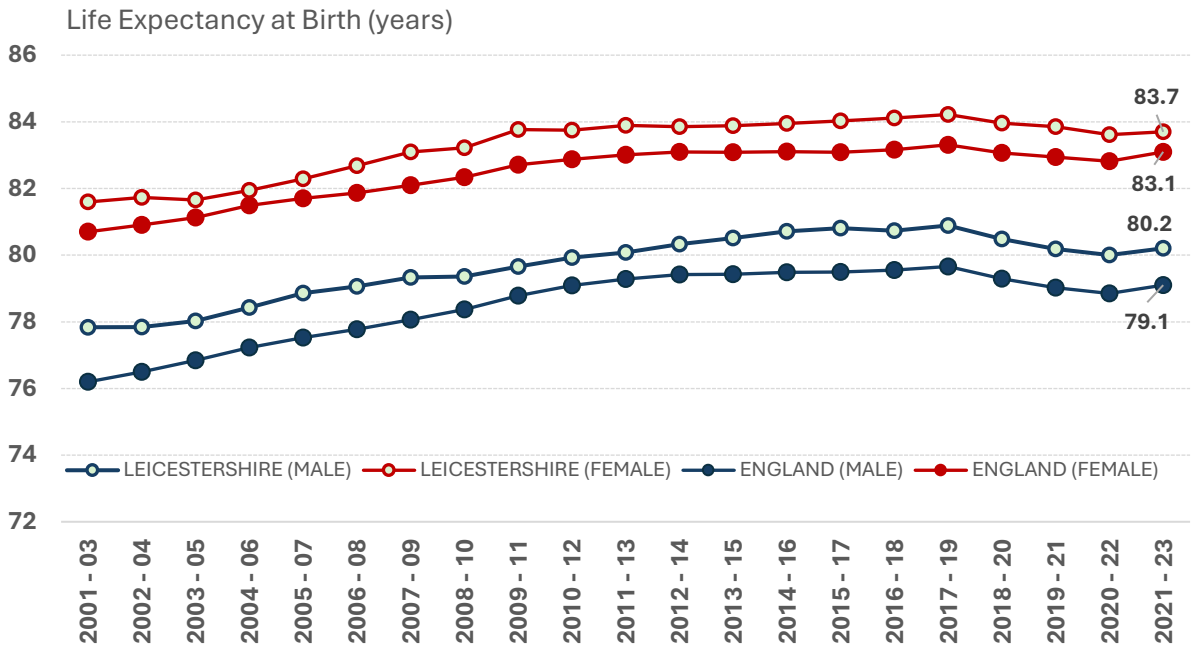
Based on mortality experienced by Leicestershire residents in the years 2021 to 2023, the local life expectancy for males is estimated at 80.2 years and for females at 83.7 years. Both estimates are significantly higher than the national figures of 79.1 and 83.1 years.

However, across England as well as in Leicestershire, life expectancy has been falling between 2017-19 and 2020-22, caused by a sharp increase in mortality (resulting in fall of life expectancy) in 2020, due to the COVID-19 pandemic (Figure 8).

It is also of note that the healthy life expectancy for Leicestershire residents is estimated at only 62.7 years for males and 62.6 years for females (statistically similar to the national average). Thus, men are estimated to have more than 16 years and women 21 years of ill-health in later

life.

Figure 8 Trends in Life Expectancy



Source: Office for Health Improvement and Disparities: Public health profiles. © Crown copyright 2025 https://fingertips.phe.org.uk/

4.5.4. Burden of Disease

Details of conditions on the Quality and Outcomes Framework register are given in Table 5 below.

- Hypertension, highest prevalence on Leicestershire registers - increased by 13,132 registered patients - from 15.2% in 2020/21 to 16.3% (N= 123,098) and significantly higher than England average.
- Diabetes, the second most prevalent condition (N=47,902) – from 7% to 7.7% for the population aged 17 years and above.
- Asthma, the third most prevalent condition (N= 50,041) – increased from 6.7% to 7.0% (by 4,503 cases).

Among the measured risk factors, the prevalence of smoking has shown an encouraging downward trend and was significantly lower than the national average. The prevalence of obesity was also lower, although the recent trends are not available for this indicator.

Note that none of these rates are age adjusted so may be misleading.

Table 5 Burden of disease - Quality and Outcomes registers for 2023/24 (Source: OHID 2025)

QOF Register	England (%)	Leicestershire (%)	Trend
Hypertension	14.8	16.3	
Smoking prevalence in adults - current smokers	14.7	12.6	getting better
Obesity (new definition)	12.8	11.8	*
Diabetes	7.7	7.7	
Asthma	6.5	7.0	*
Chronic Kidney Disease	4.4	4.6	
Coronary Heart Disease	3.0	2.9	
Atrial fibrillation	2.2	2.5	
Stroke	1.9	1.9	
COPD	1.9	1.7	
Heart Failure	1.1	1.4	
Depression (new diagnosis)	1.5	1.3	
Osteoporosis	1.1	1.1	
Rheumatoid Arthritis	0.8	0.9	
Mental Health	1.0	0.8	
Learning disability	0.6	0.4	

* cannot be calculated
recent trend increasing
recent trend decreasing
no significant change
significantly higher than national average
significantly lower than national average

4.6. Projected Health Needs

4.6.1. Population Projections

The currently available projections are based on 2018 population estimates published by the ONS[9], which in turn are based on now 14 years old Census 2011 population figures. These projections are likely to be rebased by the ONS using Census 2021 results, with a planned release in summer of 2025. With this important caveat in mind the following are therefore indicative projections only at this stage for 2035[10] (Table 6):

- The population of Leicestershire on the caveated figures is projected to increase by 8.6% to c818,000 in the next decade, an increase of c64,500 people. This increase is 2.3 times higher than the average for England (3.7%).
- The greatest change is expected in the oldest population group (80 and above), accounting for nearly 16,400 (36% increase) additional elderly people. This is above the

projected average for England of 30.5% growth. Projected growth in other groups is also higher than the national average.

- The highest population growth is expected in North-West Leicestershire (by 12%) and Blaby (by 10%); lowest in Melton (2%) and Oadby and Wigston (4%). North-West Leicestershire is also predicted to experience the highest population growth for the over 65s (29% vs national 21%), with lowest growth in Oadby and Wigston (13%) (Table 7).

Table 6. Leicestershire population projections 2025-2035 based on 2011 data

Year / Age:	2025	2027	2029	2031	2033	2035	Local Growth*		England*
	Number (000s)						# (000s)	%	%
0-19	171.5	174.0	175.8	176.7	177.1	178.1	6.6	3.8%	-3.6%
20-39	175.1	177.9	180.0	181.6	183.3	184.5	9.3	5.3%	1.7%
40-64	244.4	246.1	248.1	250.7	253.2	255.9	11.5	4.7%	0.0%
65-79	117.4	120.2	123.3	128.3	133.2	138.1	20.7	17.6%	16.8%
80+	45.2	50.1	54.7	57.6	60.1	61.7	16.4	36.4%	30.5%
Total	**753.7**	**768.2**	**782.0**	**795.0**	**806.9**	**818.2**	**64.5**	**8.6%**	**3.7%**

* Change between 2025 and 2035

Source: Office for National Statistics 2024

Table 7 Population growth in Leicestershire districts - elderly and overall

	> 65s Growth*		Total Growth*	
	# (000s)	%	# (000s)	%
Blaby	4,766	21%	10,868	10%
Charnwood	8,485	23%	17,485	9%
Harborough	5,990	25%	8,225	8%
Hinckley and Bosworth	5,924	21%	10,685	9%
Melton	3,437	26%	1,070	2%
North West Leicestershire	6,895	29%	13,991	12%
Oadby and Wigston	1,673	13%	2,213	4%
Leicestershire	37,167	23%	64,537	9%

* Change between 2025 and 2035

4.6.2. Long Term Conditions

In the next decade (from 2025 to 2035) the number of older people with limiting long term illness is predicted to increase by almost a quarter (23.5%, over 18 thousand) (Table 8). This forecast includes nearly a 9.2 thousand increase on those whose day-to-day activities could be

severely limited.

The highest increase is predicted for North-West Leicestershire (28.3%), the lowest for Oadby and Wigston (13.9%).

The forecasts are strongly linked to older population projections (ONS 2018-based) – the variation is thus linked to the age structure of the district population.

Table 8 Future impact of chronic illness - Leicestershire population aged 65 and over with a limiting long term illness whose day-to-day activities are limited (a little or a lot)

	Limited a little			Limited a lot			Total		
	2025	2035	change (%)	2025	2035	change (%)	2025	2035	change (%)
Blaby	5,895	7,022	19.1	5,119	6,329	23.6	11,014	13,351	21.2
Charnwood	9,708	11,820	21.8	8,011	10,058	25.6	17,719	21,878	23.5
Harborough	5,888	7,329	24.5	4,494	5,828	29.7	10,382	13,157	26.7
Hinckley and Bosworth	7,245	8,713	20.3	6,289	7,923	26.0	13,534	16,636	22.9
Melton	3,396	4,260	25.4	2,620	3,389	29.4	6,016	7,649	27.1
North West Leicestershire	6,309	8,001	26.8	6,165	7,998	29.7	12,474	15,999	28.3
Oadby and Wigston	3,351	3,779	12.8	2,957	3,407	15.2	6,308	7,186	13.9
Leicestershire	41,833	50,899	21.7	35,708	44,877	25.7	77,541	95,776	23.5

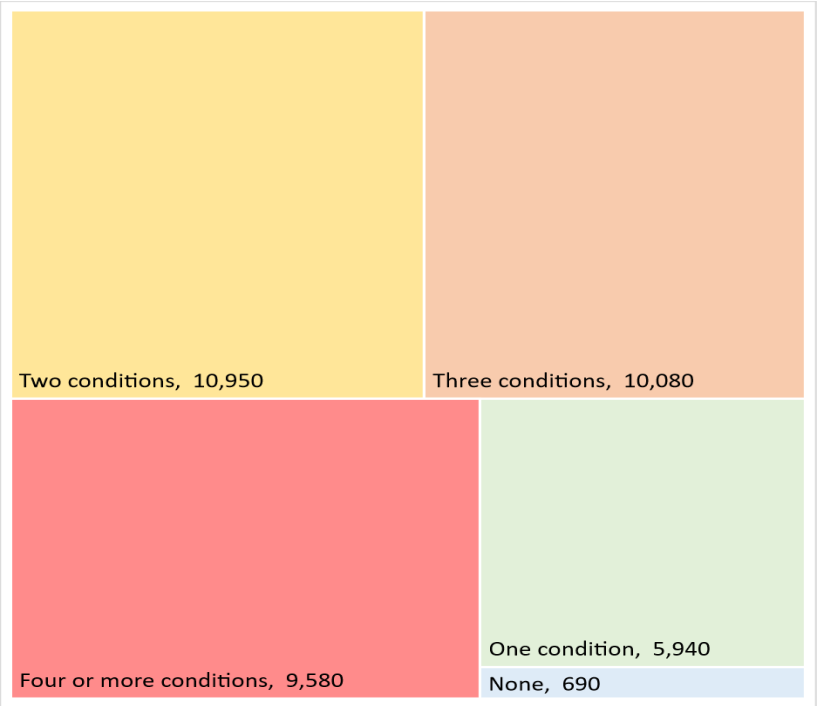
Figures may not sum due to rounding.
Source: POPPI 2024

At the national level, the population projections and current morbidity trends point toward a significant rise in the numbers of people with several chronic conditions (both mental and physical) in the near future[11]. In addition to the overall population increase over the next ten years, statistical models based on national surveys[12] allow for approximate projections of morbidity and multi-morbidity for Leicestershire.

According to the ONS 2018 population projections, the local population aged 65 and above is likely to increase between 2023 and 2033 by at least 37 thousand. It is estimated that the vast majority (82% or 30.3 thousand) will have at least two chronic conditions, with more than a quarter (26%, nearly 9.6 thousand) projected to suffer from four or more chronic diseases (Figure 9).

In addition to the older population increase, these models predict the percentage rise in the prevalence of specific chronic conditions. For Leicestershire, it is estimated that, by 2033, there could be an additional 27 thousand residents (aged 65 and over) suffering from arthritis, 22 thousand with hypertension, 15 thousand additional cases of cancer, 14 thousand with respiratory conditions and 11 thousand with diabetes.

Figure 9 Projected increase in morbidity and multi-morbidity for the Leicestershire population aged 65 and above in the decade between 2023 and 2033.



4.6.3. Housing Needs

In 2018 the Leicester City and Leicestershire County Councils, the seven local borough and district authorities and the former Leicester and Leicestershire Enterprise Partnership (LLEP) agreed a non-statutory Strategic Growth Plan, putting forward the proposals for future development, including housing provision, needed to support population change, meet housing needs and support economic growth until 2050.

Following changes in economic and housing market dynamics and national policy (including introduction of the standard method for calculating housing need which led to an identified unmet need of 1,169 homes per annum in Leicester City), partners embarked on further work to understand these impacts.

In 2022 a Housing and Economic Needs Assessment (HENA) and Housing Distribution Paper was published to consider Leicester City's unmet need and an alternative distribution of housing provision for the Leicester and Leicestershire Housing Market Area (Table 9) to 2036. This redistribution saw a 36% increase in the minimum number of houses that would need to be delivered in Leicestershire.

Table 9 Local Housing Need and proposed redistributed housing provision

	Local Housing Need (dwellings per annum) (2022-Standard Method)	**Proposed redistributed housing provision (dwellings per annum)**
Blaby	341	687
Charnwood	1,111	1,189
Harborough	534	657
Hinckley & Bosworth	472	659
Melton	231	300
North West Leicestershire	372	686
Oadby & Wigston	188	240
Leicestershire Total	**3,249**	**4,418**
Leicester	2,464	1,295
Leicester and Leicestershire Total	5,713	5,713

Source: Leicester & Leicestershire Housing & Economic Needs Assessment Housing Distribution Paper (June 2022)

In December 2024, Government published a new National Planning Policy Framework and a new Standard Method for calculating housing need, which was further revised in March 2025. This reduced the housing need in Leicester City by 884 dwellings per annum, whilst the Housing Market Area total increased by 122 dwellings per annum (2.13%) (Table 10).

Table 10 Local Housing Need estimates in 2022 and 2025

	Local Housing Need (dwellings per annum) (2022 Standard Method)	**Local Housing Need (dwellings per annum) (2025 Standard Method)****
Blaby	341	534
Charnwood	1,111	982
Harborough	534	723
Hinckley & Bosworth	472	659
Melton	231	363
North West Leicestershire	372	610
Oadby & Wigston	188	384
Leicestershire Total	**3,249**	**4,333**
Leicester	2,464	1,580
Leicester and Leicestershire Total	5,713	5,835

**Source: Leicester & Leicestershire Housing & Economic Needs Assessment Housing Distribution Paper (June 2022)*

***Source: MHCLG, Standard Method (March 2025)*

The updated National Planning Policy Framework in December 2024 gave provision for transitional periods to the new Standard Method, meaning that some of the authorities across Leicester and Leicestershire are still working to the redistributed housing figures outlined in 2022 HENA Housing Distribution Paper, whilst some will be required to work from the new 2025 Standard Method figures. At the time of writing, an update to the HENA's Housing Distribution Paper is underway in response to the new Standard Method and any revised or new unmet need (from any Housing Market Authority partner authority) will need to be taken into account in the redistribution, subject to evidence.

Further work on forecasting the likely growth in housing over the next three years, including main locations of housing growth, is ongoing. The results will be included in the final draft of the PNA, in the summer of 2025. Although the new housing developments are likely to provide for the future local population growth, estimated by the ONS, additional migration needs to be monitored. It is essential that new housing developments take into account the availability of local pharmaceutical services.

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5. Local Health Priorities

5.1. National Context

NHS Long Term Plan (LTP)[13] was published in January 2019 to set out the priorities for healthcare for the next ten years. It includes chapters on new service models, action on prevention and health inequalities, and progress on care quality and outcomes. It acknowledges the essential role of pharmacists in delivering care in the community, uniquely placed to support urgent care and promote patient self-care and self-management. In envisages the creation of fully integrated community-based healthcare with developing truly multi-disciplinary teams. It also identifies community pharmacists as part of the process of improving the effectiveness of approaches such as NHS Health Checks.

Core20PLUS5[14] aims to support the reduction of health inequalities nationally and locally (at ICS level), concentrating on the most deprived 20% of the national population (CORE20) as identified by the Index of Multiple Deprivation (IMD) and those within an ICS who are not identified within the core 20% but who experience lower than average outcomes, experience or access (PLUS). It focuses on five clinical priority areas – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding.

The drive to modernise the NHS (forthcoming **Ten Year Health Plan**[15]) is to be based on three shifts - moving care from hospitals to communities, making better use of technology and focussing on preventing sickness.

5.2. Local Priorities

The Leicestershire **Joint Health and Wellbeing Strategy (2022-32)** was published in 2022. The Strategy is the Health and Wellbeing Board's response to the health and wellbeing needs identified in the Joint Strategic Needs Assessment.

The Strategy is aligned with the Integrated Care System's requirement for the development of a Place Based Plan. A life course approach has been used to identify high level strategic, multi-organisational priorities for the next 10 years that will need to be addressed in order to improve the needs of the population and provide clear accountability to the Leicestershire Health and Wellbeing Board (Figure 10).

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Figure 10 Leicestershire Health and Wellbeing Strategy priorities for 2022-32

The **'One LLR' Our Primary Care Strategy 2022-2025**[16] set out a vision for primary care across LLR, building on existing local health and wellbeing strategies and place led plans. It acknowledged the importance of including urgent care, pharmacy, dentistry, and optometry services, not just general practice, to ensure better care continuity. It highlights the focus on achieving both nationally mandated deliverables and local primary care delivery priorities for LLR. Some of important goals in the contexts of pharmaceutical services include:

- Developing an integrated, multi-disciplinary model of care focused on prevention, self-care, and shared health outcomes.
- Implementing new care models for vulnerable and long-term conditions patients.
- Building services tailored to local neighbourhoods.
- Improving communication and engagement to encourage people to seek help when needed.
- Empowering people to manage their own health and support prevention and self-care.
- Providing care in appropriate locations, at the right time, and in the right way.
- Offering local primary care facilities with integrated teams and a range of services.

The vision takes into account the national context, ongoing initiatives and system challenges

across the NHS, as well as changing models of care (such as access to pharmacies through CPCS). It includes evolution of primary care to include wider care services, such as urgent care, pharmacy, dentistry and optometry.

It is based around three person-centred themes – (1) population, health quality, prevention, (2) joining up, and (3) access to care closer to home. Key priorities for delivery, in the pharmacy context, include the redesign of care pathways (to include CPCS, now Pharmacy First service), as well as easy and equitable access to a range of services and support. These will be enabled through better workforce development, estates and infrastructure, technology and innovation, governance and leadership, communications and engagement, and finance and contracting. Integration of pharmaceutical services into wider primary care lies at the heart of this Strategy.

Integration of community pharmacies into front-line primary care service is one of the main priorities in the **Medicines Optimisation Partnership Operational Plan for 2025/26**. Expanding the range of services provided by pharmacies aims to reduce the demand on primary and secondary services. This could be achieved though growth of both self-referrals and referrals from GP practices into community pharmacy enhanced services. The key pharmacy integration programmes include:

- Pharmacy First service
- Community Pharmacy Blood Pressure Service
- Community Pharmacy Contraception Service (initiation and continuation of combined oral contraception)
- Independent prescribing pathway (IPP) - using prescribing pharmacists based in a community pharmacy to manage acute conditions, unavailable medicines and perform asthma reviews and medicines optimisation.
- Referrals for NHS Trusts
- Piloting of appointment booking system for Pharmacy First referrals from GP practices

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6. Pharmaceutical Services

6.1. Community Pharmacy Contractual Framework

The Community Pharmacy Contractual Framework (CPCF) is the agreement between NHS England and pharmacy contractors in England that governs the services provided by community pharmacies and how they are funded. The CPCF sets out the services that need to be provided, how quality is assured and other expectations, such as safety[17].

From 1st of April 2023, Integrated Care Boards have been responsible for the commissioning of Pharmaceutical Services, while NHS England has the responsibility to identify national priorities, setting outcomes and negotiating national contractual frameworks, such as the CPCF.

Many services provided by community pharmacists are commissioned locally according to the needs of the area. Locally commissioned community pharmacy services can be contracted via a number of different routes and by different commissioners, including LLR ICB and NHS England Midlands.

All contracted pharmacies need a responsible pharmacist on site at all times. Their role includes securing the safe and effective running of the pharmacy (including during absences); it doesn't have to be the owner of the pharmacy.

6.2. Prescribing Activity

There were over 14.79 million items prescribed in 2023/24 in Leicestershire which is substantially higher than 13.19 million in 2020. This figure represents 20 items per head of population in 2023/24. The lowest rate was in Oadby and Wigston (17.7) and highest in Hinckley and Bosworth (24.2) (Table 11).

Table 11 Rate of prescribing (total items prescribed in 2023/24) in Leicestershire

District	Items prescribed	Registered population (2024)	Rate (items per head of population)
Blaby	1,947,962	101,841	19.1
Charnwood	3,710,785	202,240	18.3
Harborough	2,092,345	96,828	21.6
Hinckley and Bosworth	2,742,914	113,509	24.2
Melton	893,299	47,778	18.7
North West Leicestershire	2,231,763	109,274	20.4
Oadby and Wigston	1,173,672	66,361	17.7
LEICESTERSHIRE	**14,793,340**	**737,831**	**20.0**

Source: NHS Business Services Authority. English Prescribing Dataset (EPD) 2024

Almost a third of all prescribed items (32.1%, over 4.76 million) were for cardiovascular conditions, followed by 18% (2.67 million) for central nervous system and 11.4% for endocrine

conditions (Table 12).

Table 12 Items prescribed in Leicestershire in 2023/24, by BNF chapter

BNF Chapter	Items Prescribed	% of Total
Cardiovascular System	4,755,509	32.1
Central Nervous System	2,665,584	18.0
Endocrine System	1,679,700	11.4
Gastro-Intestinal System	1,357,353	9.2
Respiratory System	900,976	6.1
Nutrition and Blood	717,099	4.8
Appliances	481,200	3.3
Infections	418,126	2.8
Obstetrics, Gynaecology and Urinary-Tract Disorders	400,869	2.7
Musculoskeletal and Joint Diseases	390,189	2.6
Skin	282,492	1.9
Eye	205,081	1.4
Immunological Products and Vaccines	142,427	1.0
Ear, Nose and Oropharynx	133,364	0.9
Stoma Appliances	102,409	0.7
Malignant Disease and Immunosuppression	58,602	0.4
Dressings	35,064	0.2
Incontinence Appliances	33,137	0.2
Anaesthesia	28,940	0.2
Other Drugs and Preparations	5,218	0.0
LEICESTERSHIRE Total	14,793,340	100.0

Source: NHS Business Services Authority. English Prescribing Dataset (EPD) 2024

Similar prescribing patterns were observed in Leicestershire districts (Figure 11); the proportionately lowest CVS prescribing was in Melton (less than 30%) and highest in Harborough (34.1%). CNS highest in Melton (19.6%) and lowest in Oadby and Wigston (16.5%) – again this may be age related.

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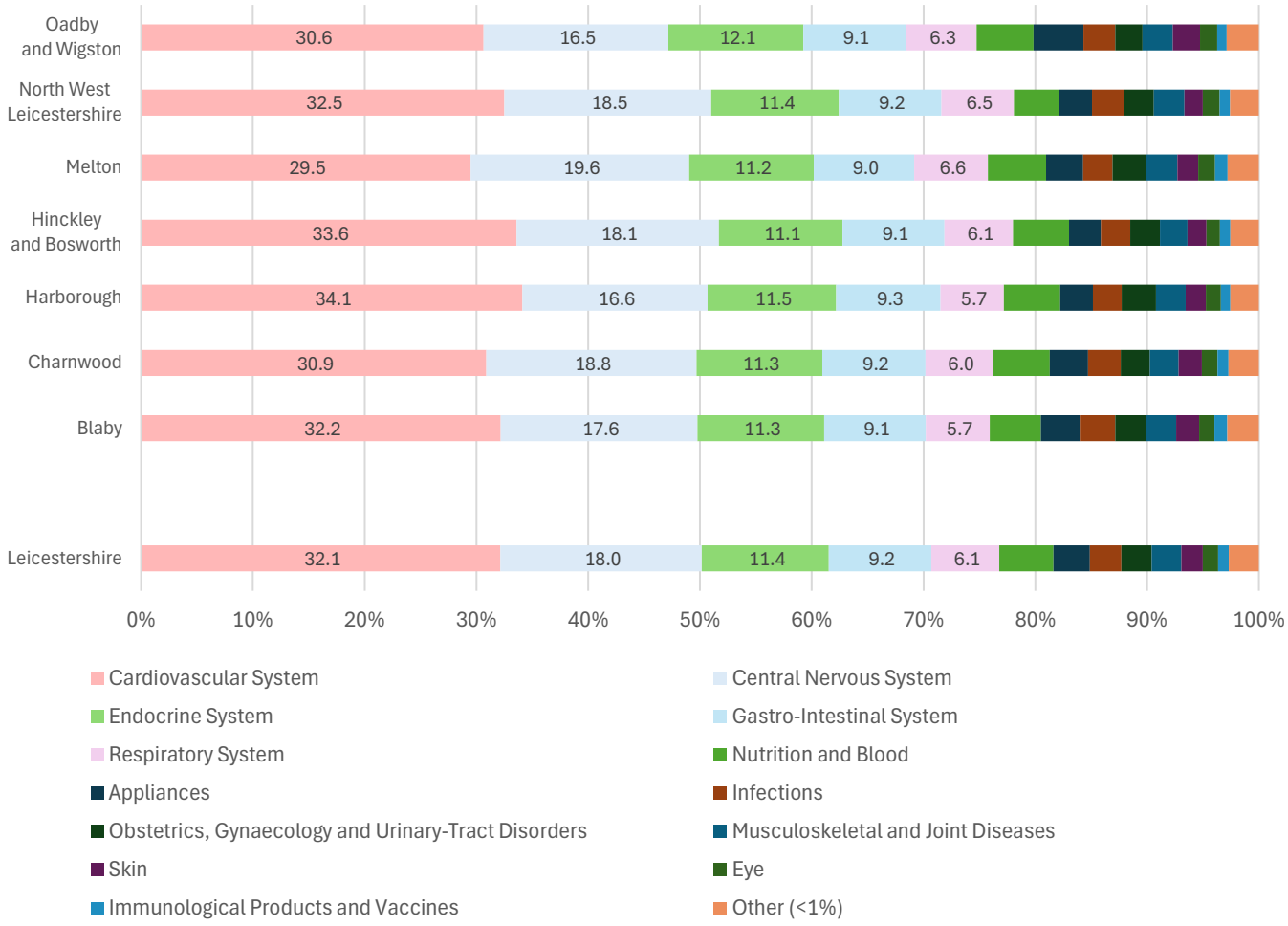
Figure 11 Prescribing patterns across Leicestershire districts in 2023/24



Source: NHS Business Services Authority. English Prescribing Dataset (EPD) 2024

6.3. Access to Pharmacies

In addition to local pharmacies described in this section, Leicestershire residents have access to all 4,095 Distance Selling Pharmacies (DSPs) across England. DSPs were described in the section 4, page 13.

6.3.1. Location

In September 2024 there were 133 community pharmacies located in Leicestershire, 1 DAC and 16 dispensing General Practices[6]. Their locations are presented on Figure 12. The highest number is in Charnwood (N=43), lowest in Melton (N=9) – see Table 13 in the section below,

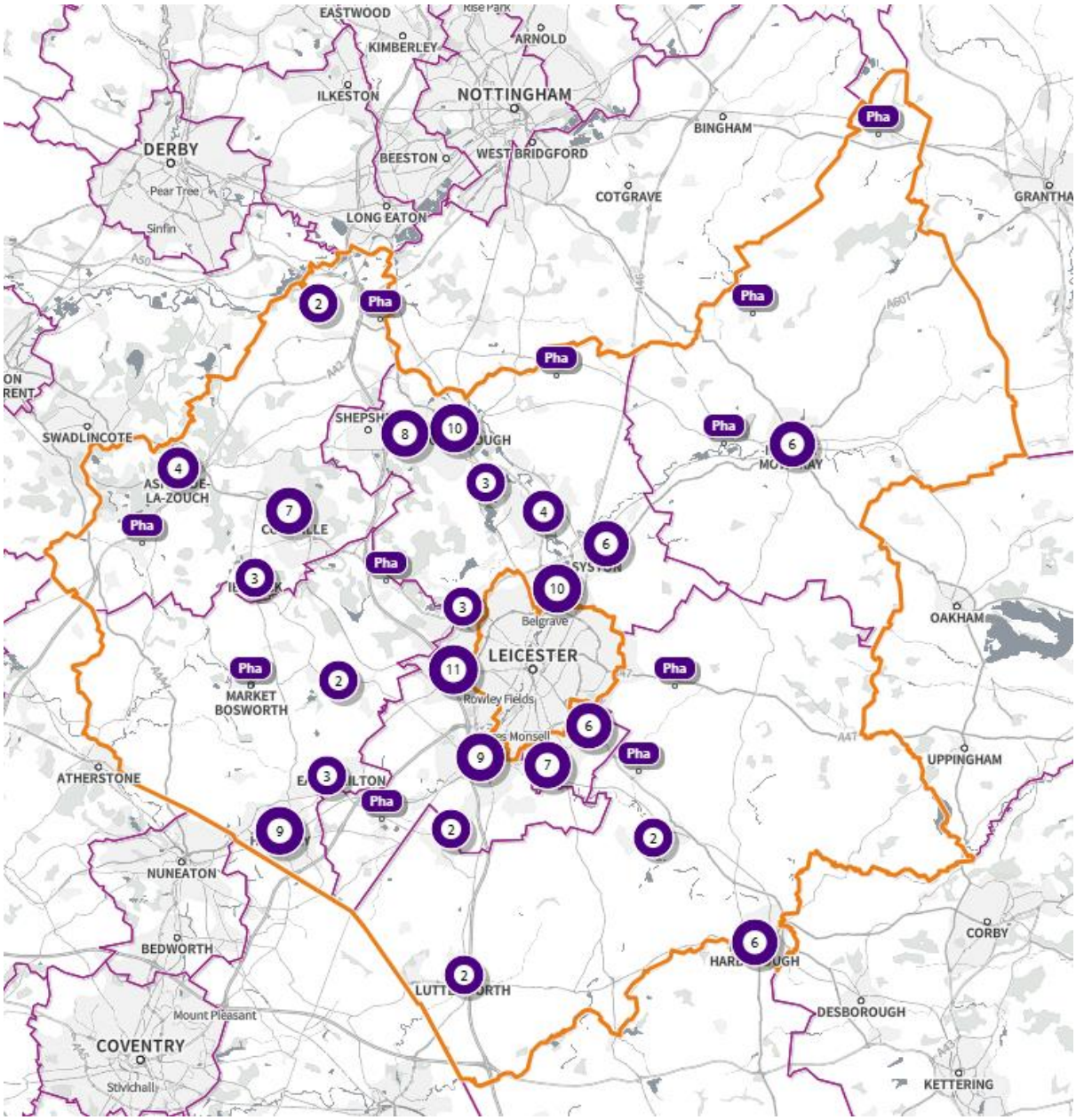
[5] In 2023/4, source: NHSBCS - General Pharmaceutical Services - 2015/16 to 2023/24 - Number of Pharmacies by attribute

[6] This has risen to 20 in March 2025 (SHAPE 2025)

which discusses the population coverage for Leicestershire and its districts.

There were also five *distance selling pharmacies* (DSP) in Leicestershire in September 2024, 3 in Charnwood, one in Hinckley and Bosworth and one in Oadby and Wigston.

Figure 12 Location of pharmacies in Leicestershire



Source: NHSBSA Consolidated Pharmaceutical List 2024/25Q2 and SHAPE

6.3.2. GP Dispensing

A Dispensing Doctor is a GP Practice which can dispense medicines to certain patients under specific criteria - the patient must live more than a 1.6 km (1 mile) from a retail pharmacy, or the area must be designated as a 'reserved location'. Additionally, the dispensing practice must be situated in an approved location. The patient must be on the dispensing doctor's dispensing list.

The purpose of GP dispensing is to help with access to full pharmaceutical services for patients living in rural areas.

Currently (March 2025), there are 20 dispensing GP practices within Leicestershire borders (Figure 13 shows their location relative to the rurality of the area in 2021). This total includes 5 in Harborough, 5 in North West Leicestershire, 4 in Melton, 3 in Hinckley and Bosworth, 2 in Blaby and one in Charnwood. Most of those GP practices are located within rural areas of the County.

Within a 5 km buffer from the County boundary there are further 12 dispensing GP practices – including 3 from the eastern border of the district Melton, 4 close to the border of Harborough, 3 Hinckley and Bosworth and 2 close to North West Leicestershire and Charnwood.

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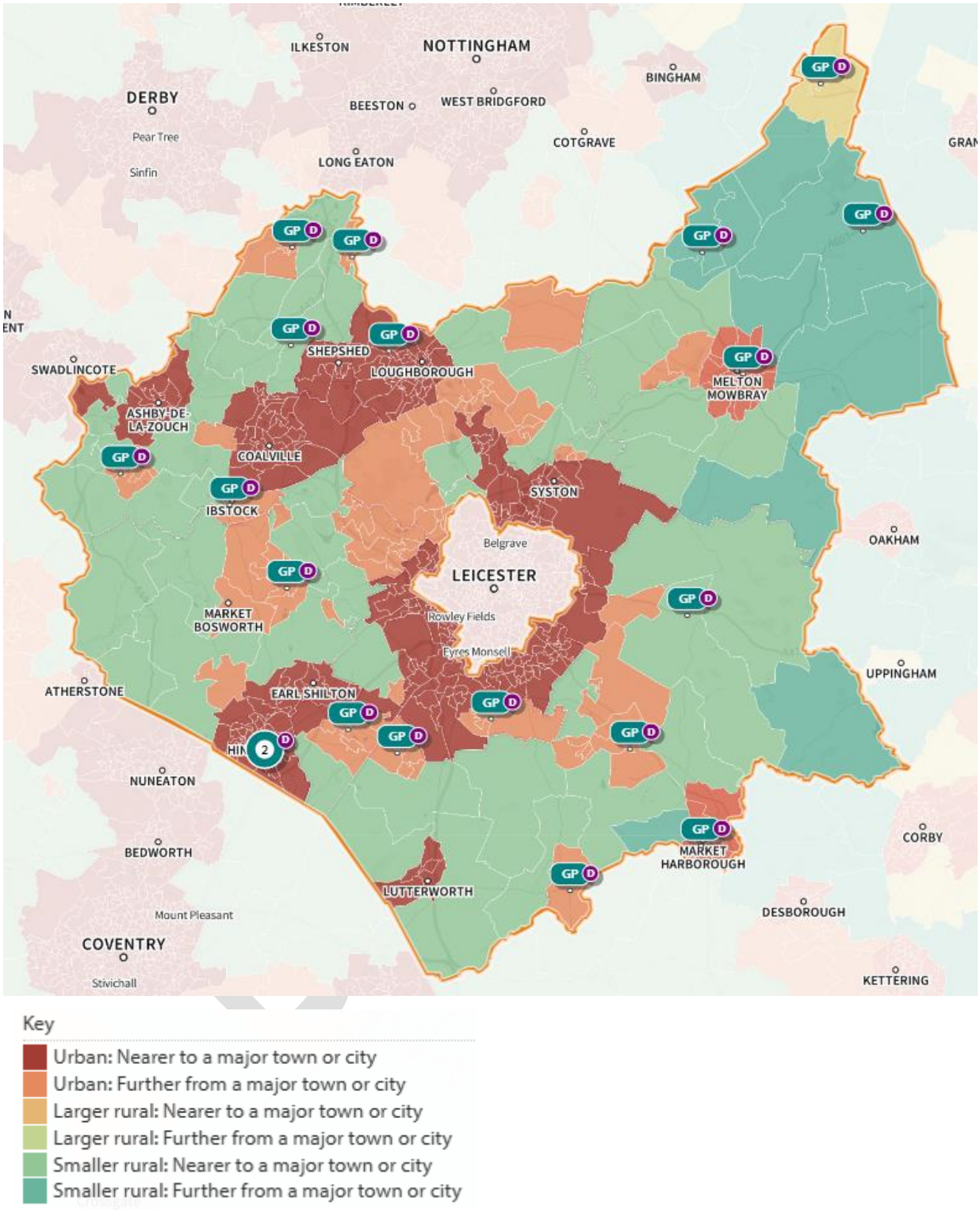
Figure 13 Dispensing GP practices located in Leicestershire and urban-rural classification (2021)



Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2025

6.3.3. Population Coverage

In England in 2023/4 there were 12,009 community pharmacies which indicates, on average 2.1 pharmacies per 10,000 population (57,690,300 population estimate in 2023).

Across Leicestershire, the rate varies between 1.3 in Harborough and 2.3 in Charnwood, with the county average of 1.8 per 10,000 population (Table 13). The overall rate is slightly lower than 1.9/10,000 calculated for the previous PNA (2022). Adding the number of GP practices providing dispensing services, gives a rate of 2.0 per 10,000 population across Leicestershire, with lowest rate of 1.8 (Harborough, Hinckley and Bosworth, and North-West Leicestershire) and highest in Blaby (2.2).

Table 13 Community pharmacies in Leicestershire with population rate

District	Community Pharmacies	Dispensing GP Practices*	Population**	Pharmacies per 10,000	Pharmacies and Dispensing GPs per 10,0000
Blaby	21	2	105,278	2.0	2.2
Charnwood	43	1	188,010	2.3	2.3
Harborough	13	5	102,581	1.3	1.8
Hinckley and Bosworth	18	3	114,970	1.6	1.8
Melton	9	2	53,237	1.7	2.1
North West Leicestershire	17	3	110,316	1.5	1.8
Oadby and Wigston	12	0	59,623	2.0	2.0
Leicestershire	**133**	**16**	**734,015**	**1.8**	**2.0**

** NHS Digital, NHS Payments to General Practices 2022/23*
***ONS Mid-2023 Population Estimate*

6.3.4. Opening Times

Pharmacy opening hours are part of pharmacies' terms of service. Most pharmacies must open for 40 core contractual hours

NHS England is responsible for administering opening hours for pharmacies, this is handled locally by ICBs (delegated responsibility). A pharmacy normally has 40 core contractual hours or 72+ for those that opened under the former exemption from the control of entry test. These hours cannot be amended without the consent of the ICB[18].

The **weekly opening hours** of Leicestershire community pharmacies are summarised in Table 14. All of the districts have at least one 100-hour pharmacy; number varies between one in Oadby and Wigston, and Melton and five in Charnwood. Except for one contractor in Charnwood all are open for at least 40 hours per week.

During the week, 28% of community pharmacies open before 9 am and 81% close at 6 pm or later.

Of those, 17 are providing services on **weekday evenings** (Monday to Friday, after 7 pm), 97 are open on **Saturdays** and 21 on **Sundays**. 17 practices are open after 7pm on Saturdays and 2 on Sunday night (Table 15).

Table 14 Weekly opening hours for Leicestershire community pharmacies

District	Less than 40 hours	40-71 hours	72-100 hours	Total
Blaby	1	18	3	21
Charnwood		37	5	43
Harborough		11	2	13
Hinkley and Bosworth		16	2	18
Melton		8	1	9
North West Leicestershire		15	2	17
Oadby and Wigston		11	1	12
Leicestershire	**1**	**117**	**16**	**133**

Source: NHSBSA Consolidated Pharmaceutical List – 2024/25Q2

Table 15 Evening and weekend opening times of Leicestershire pharmacies

District	Weekday Evening	Saturday	Sunday	Saturday Night	Sunday Night
Blaby	3	18	3	3	1
Charnwood	5	26	5	5	0
Harborough	2	9	5	2	0
Hinkley and Bosworth	3	13	3	3	1
Melton	1	8	1	1	0
North West Leicestershire	2	14	1	2	0
Oadby and Wigston	1	9	3	1	0
Leicestershire	**17**	**97**	**21**	**17**	**2**

Source: NHSBSA Consolidated Pharmaceutical List – 2024/25Q2

6.3.5. Drive and Walk Time Analysis

Using the Strategic Health Asset Planning and Evaluation (SHAPE) Place tool, it is possible to analyse how long it takes to walk or drive from any Lower Super Output Area (LSOA) to the nearest pharmacy or dispensing GP practice location. Pharmacies and dispensing GPs 1.6km outside of the Leicestershire boundary have been included in this analysis. It is important to note that not everyone will access their nearest pharmacy and may choose to access a

pharmacy outside their local area.

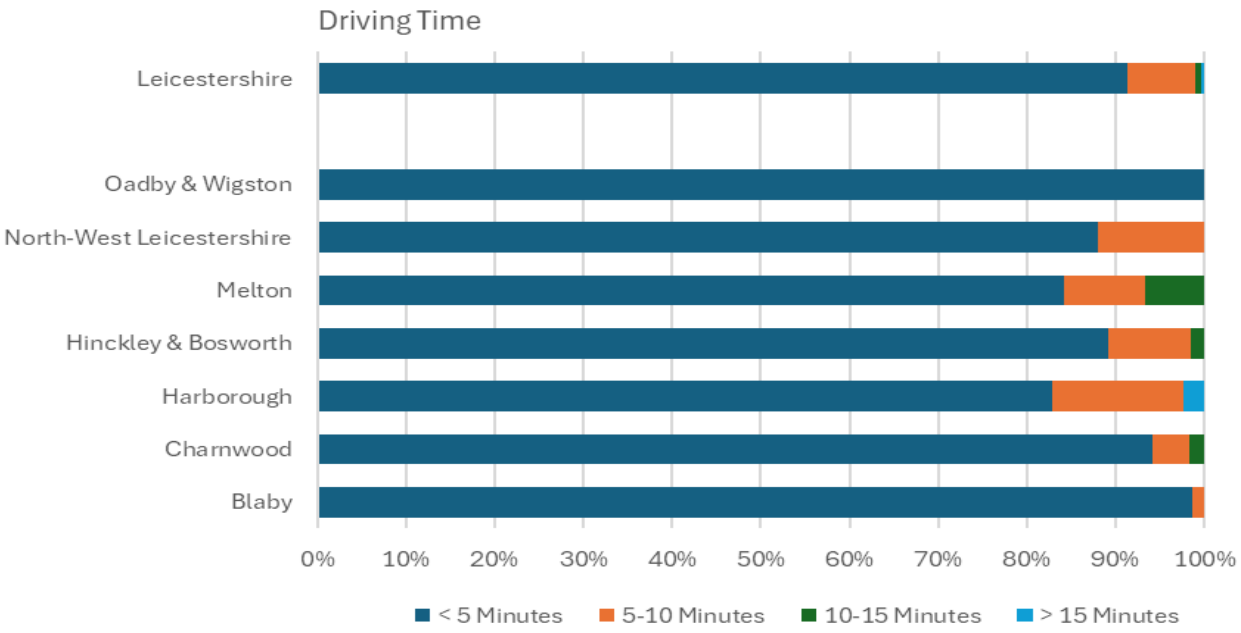
The main report presents the main results of the analysis, the detailed tables are included for reference in the **Appendix** (https://www.lsr-online.org/pna-for-2025). Please refer to those for the actual population numbers rather than the proportion presented here.

Drive Times

Overall, 91.3% of the Leicestershire population live within a five-minute drive time of a pharmacy or dispensing GP practice and 0.3% of the population (2,421 people) live outside of the 15-minute drive time boundary.

All the population outside the 15 minutes' drive time live in the district of Harborough with 2.4% of Harborough's population living more than 15 minutes' drive from a pharmacy or dispensing GP. In contrast, the whole population of Oadby and Wigston live within a 5-minute drive of a pharmacy or dispensing GP practice (Figure 14).

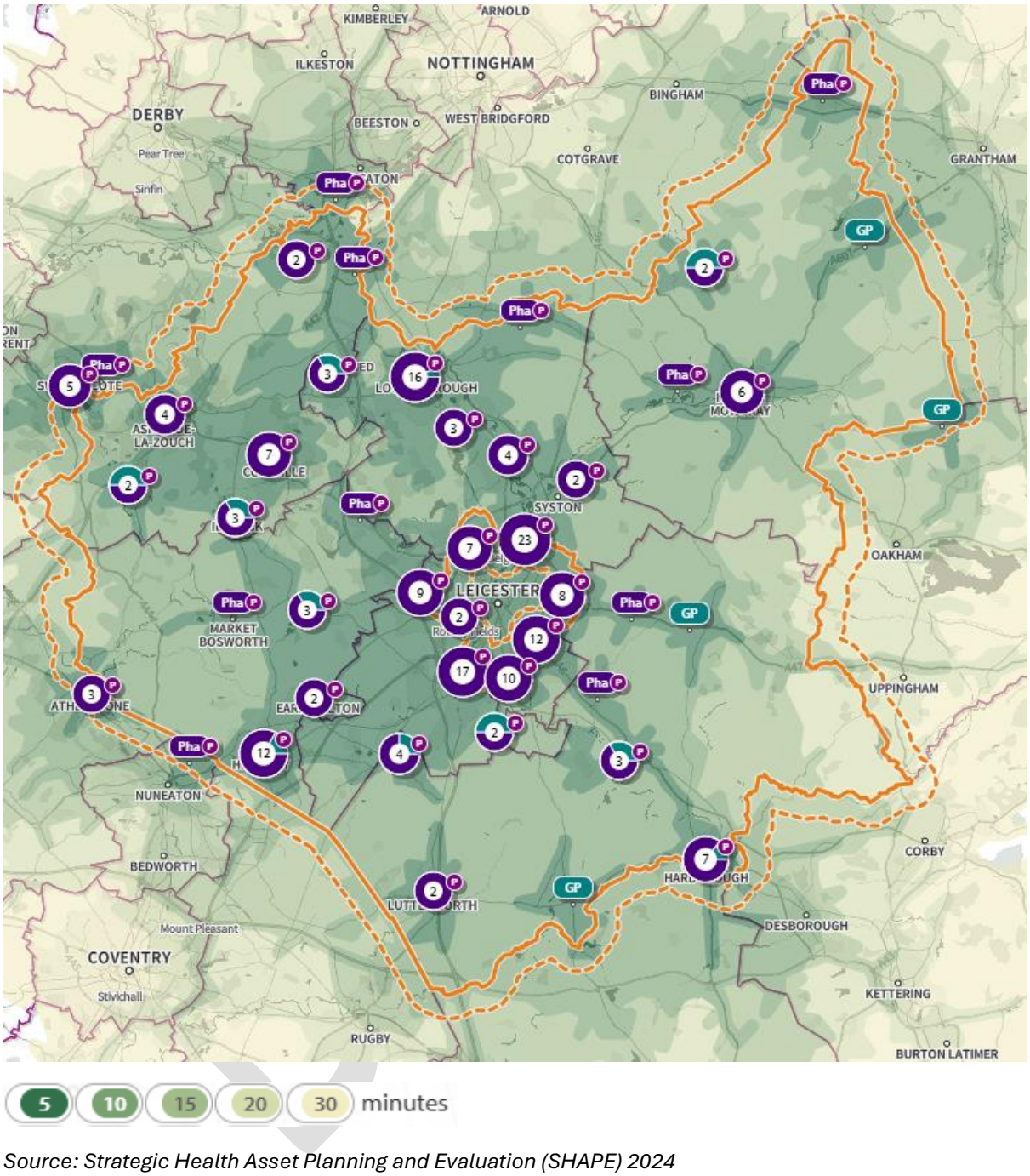
Figure 14 Population proportion by drive-time to the nearest pharmacy or dispensing GP



Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2024

The drive-time map for Leicestershire pharmacies is shown in Figure 15.

Figure 15 Drive time to nearest pharmacy (Pha) or a dispensing general practice (GP) in Leicestershire

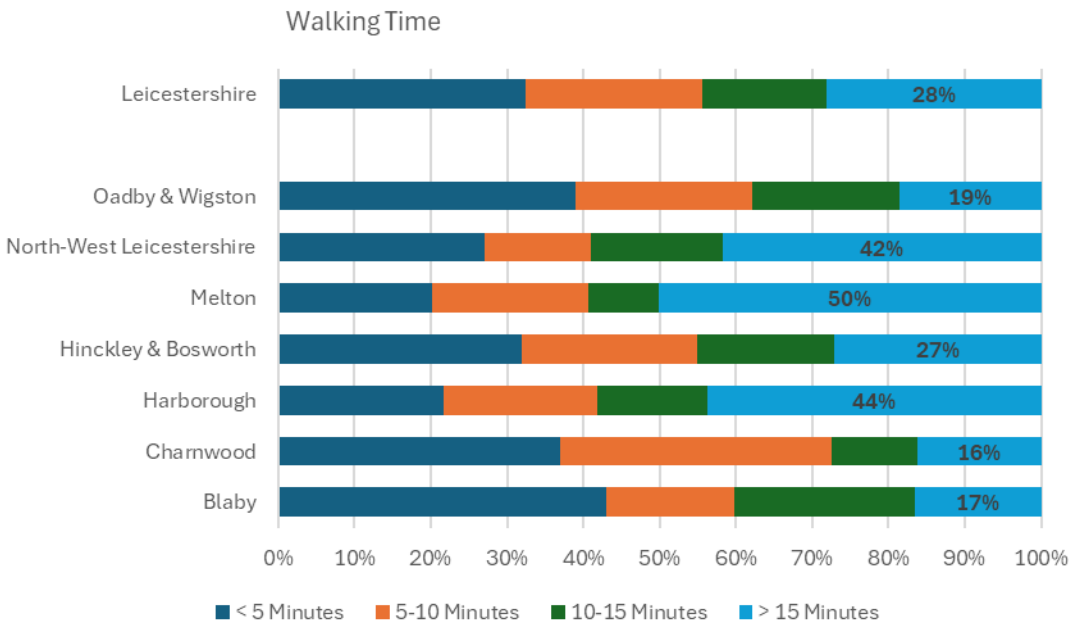


Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2024

Walk Times

Overall, just under a third (32.4%) of the county's population live within a 5-minute walk from a pharmacy, 55.6% live within a 10-minute walk, over 70% (71.9%) live within a 15-minute walk, and over a quarter (28.1%) live more than a 15-minute walk away. In particular, just over half of Melton's population (50.2%) live more than a 15-minute walk away (Figure 16).

Figure 16 Walking time to a pharmacy by district



Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2024

Figure 17 shows a map of walk time to the nearest pharmacy or dispensing GP.

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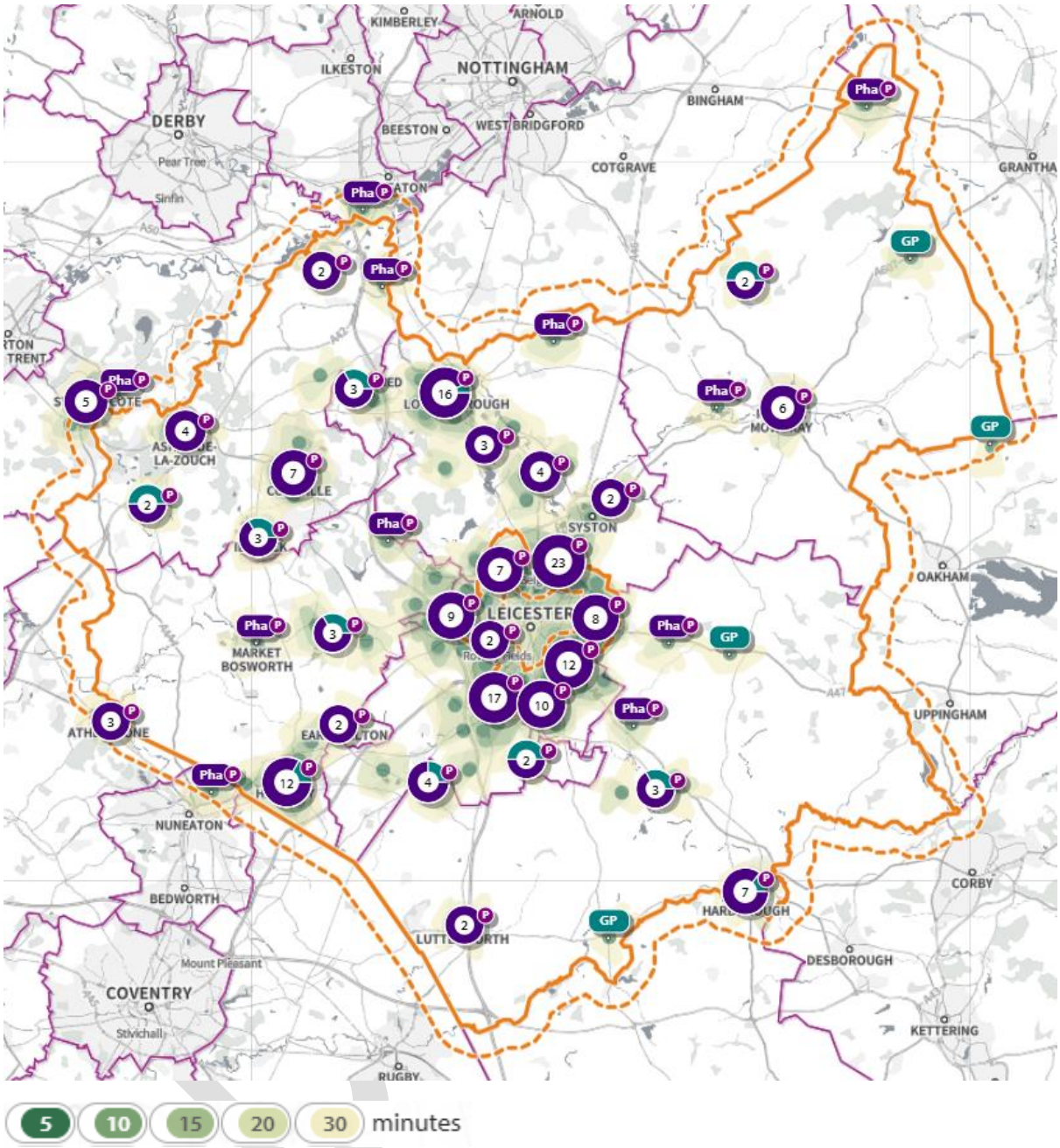
Figure 17 Walking time to the nearest pharmacy (Pha) or a dispensing GP practice (GP)



Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2024

Public Transport

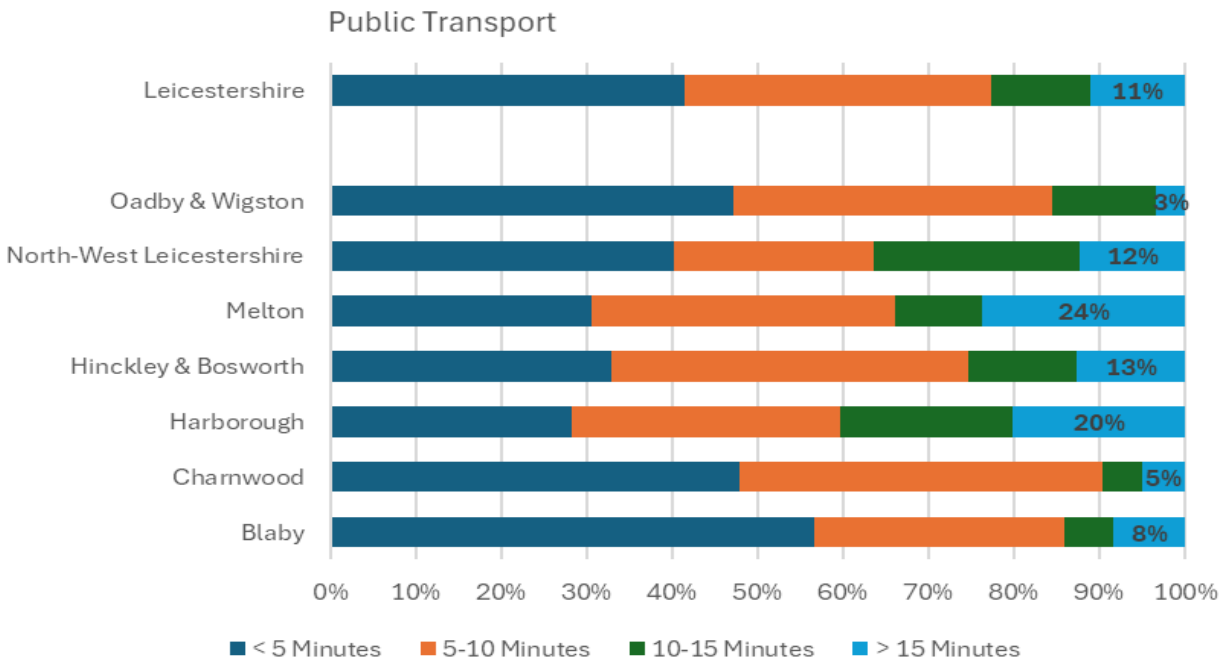
There is a range of public transport services available across the county. These can be viewed at the Leicestershire County Council website: https://www.leicestershire.gov.uk/roads-and-travel/buses-and-public-transport.

Overall, only 11.1% of the county's population live more than 15-minutes by public transport from a pharmacy or dispensing GP practice on a weekday morning, 88.9% live within a 15-

minute journey, 77.3% live within 10 minutes and 41.5% live within a 5-minute journey time (Figure 18).

Weekend and afternoon public transport services will present a different percentage of the population within these journey times.

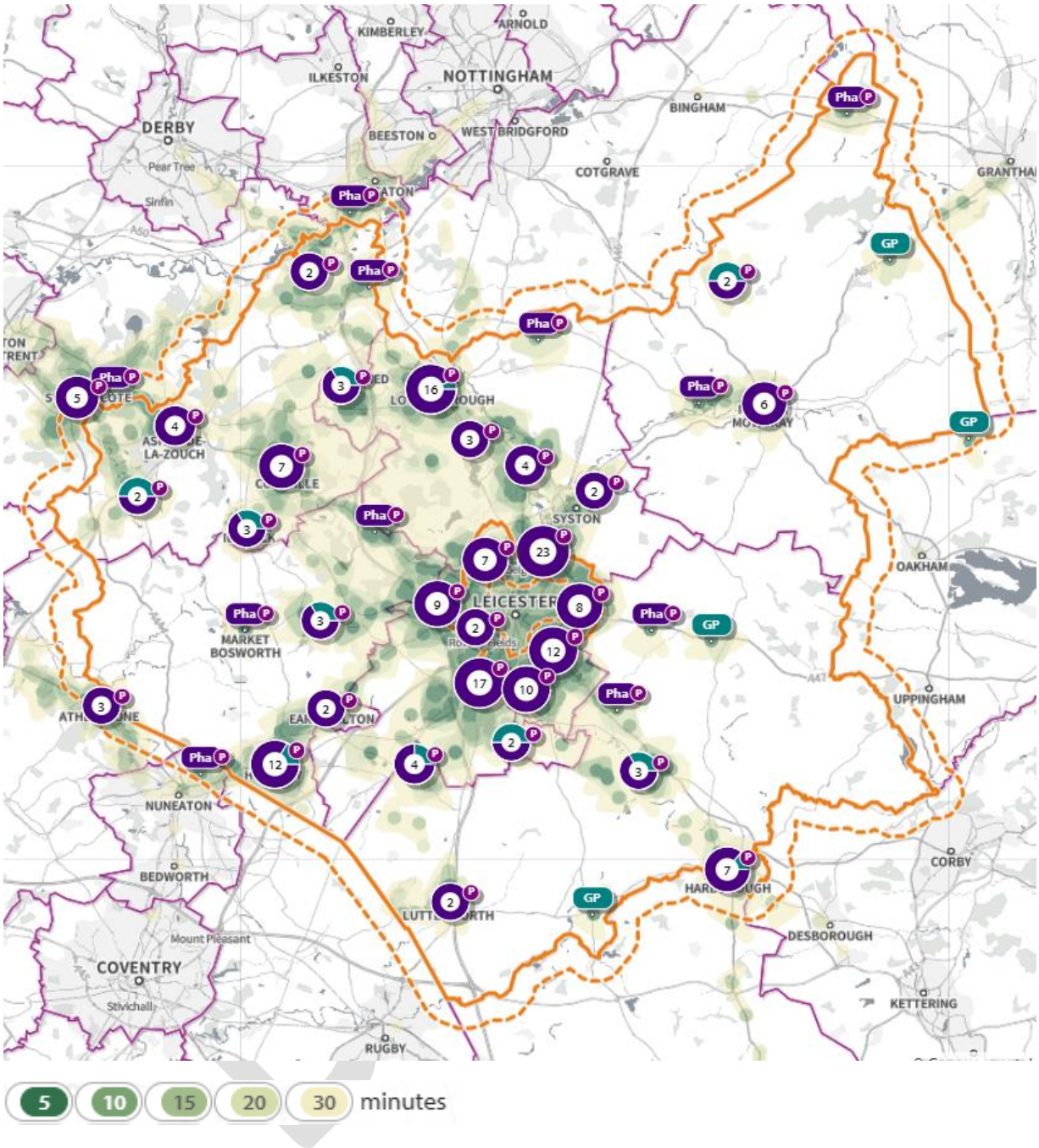
Figure 18 Public transport time by district



Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2024

Figure 19 contains a map of travel time by public transport .

Figure 19 Public transport time to the nearest pharmacy (Pha) or a dispensing general practice (GP) on weekday morning



Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2024

6.3.6. Equality of Access

This section of the report looks at the relationship between drive, walk and public transport times and aspects of the population across Leicestershire, namely age, deprivation, and rurality, in order to detect potential inequalities of access. Overall, there were no substantial inequalities between the groups – a summary of findings is presented below, with some additional details

in the Appendix.

Age

There were no significant differentials in **drive times** between the age groups, with only 0.3% - 0.4% requiring more than 15 minutes' drive to the nearest pharmacy or dispensing GP.

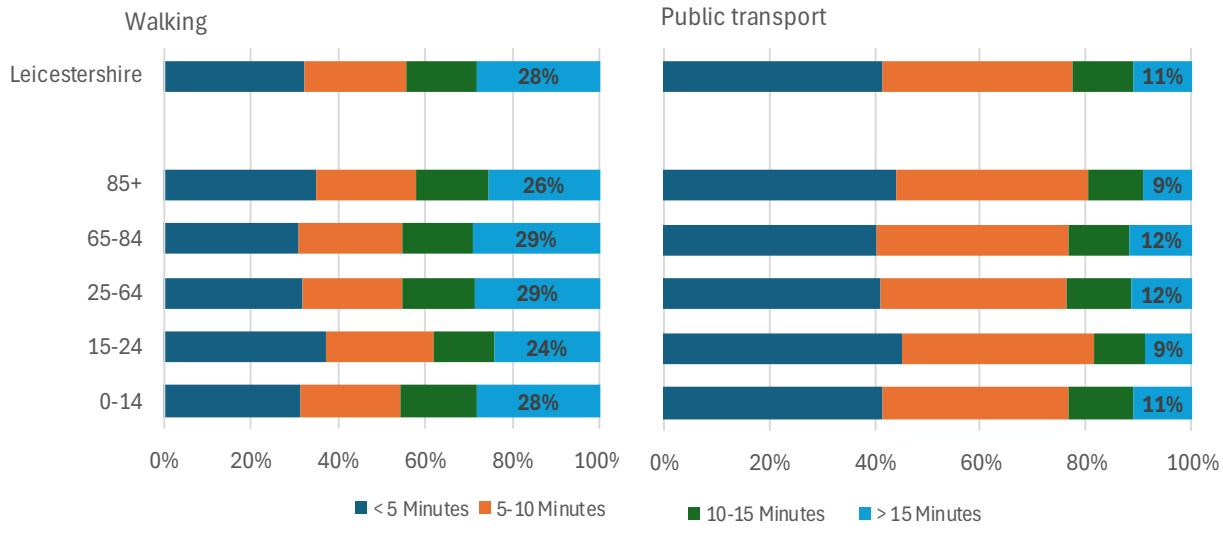
Walking and public transport access is shown in Figure 20.

Over half (61.9%) of the population aged 15-24 live within a 10-minute **walk** from their nearest pharmacy or dispensing GP practice, compared with 54.9% of the population aged 65-84 years.

Although over a quarter (28.1%) of Leicestershire's population live more than a 15-minute walk from a pharmacy or dispensing GP practice, this proportion is slightly higher for 65–84-yearolds (29.2%).

Under half of the population (41.5%) live less than 5 minutes by **public transport** on weekday mornings from a pharmacy or dispensing GP practice. This proportion is somewhat higher for 15–24-year-olds (45.1%).

Figure 20 Equality of access by age - walking and public transport



Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2024

Deprivation

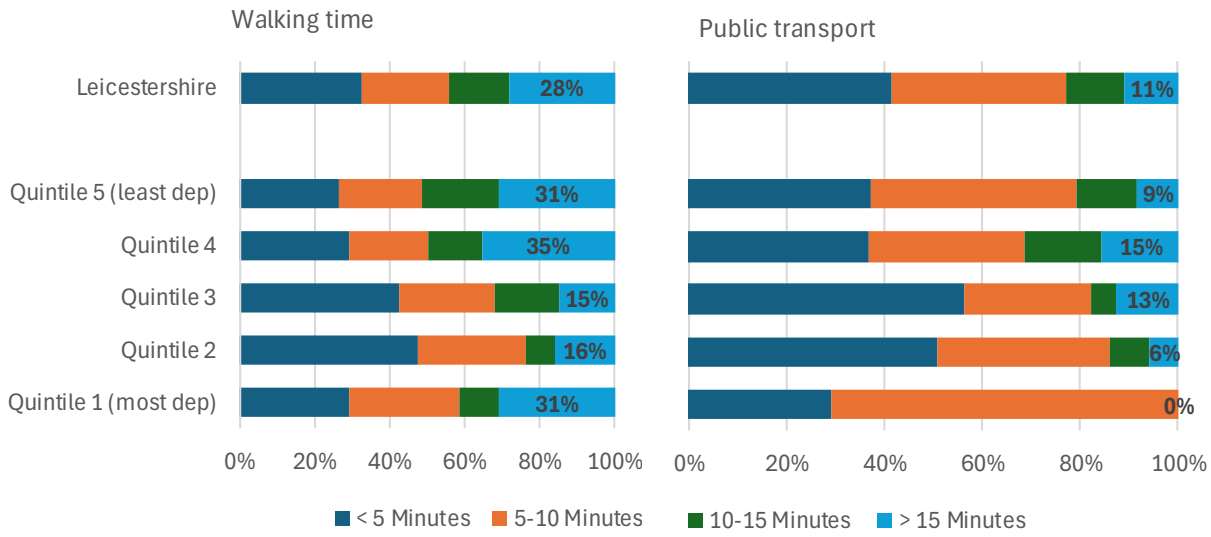
There were no significant differentials in drive times between the deprivation groups, with only 0.9% of population (N=2,421) in the least deprived quintile requiring more than 15 minutes'

drive to the nearest pharmacy or dispensing GP. Across all deprivation quintiles, 99-100% of the population can access pharmaceutical services within 10 minutes' drive.

With regards to walk time and public transport access (Figure 21):

- 30.6% of people living in Leicestershire's most deprived areas live more than a 15-minute walk from the nearest pharmacy or dispensing GP practice.
- 100% of those living in the most deprived areas in Leicestershire are within a 10-minute public transport journey on a weekday morning of a pharmacy or dispensing GP practice.

Figure 21 Equality of access by deprivation - walking and public transport



Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2024

Rurality

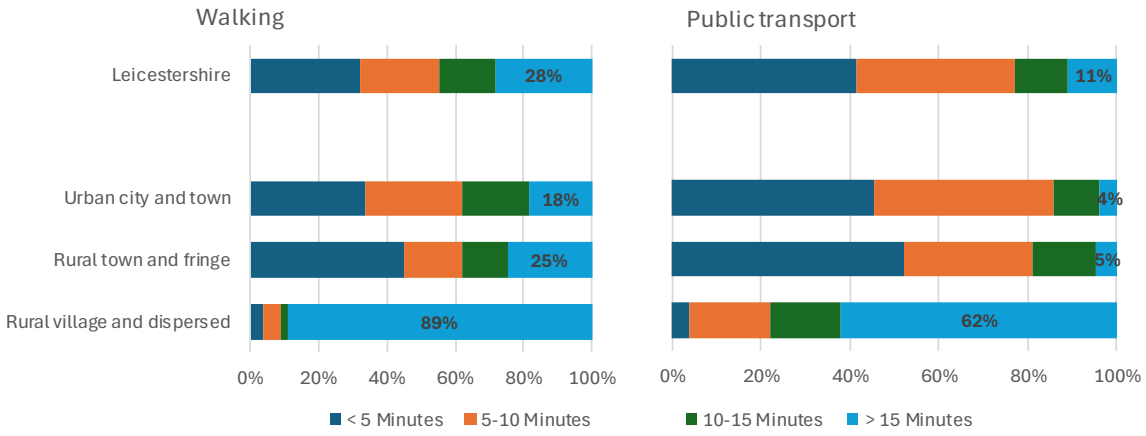
100% of those living in 'urban city and town' and 'rural town and fringe' areas in Leicestershire are within a 10-minute drive of a pharmacy or dispensing GP practice.

With regards to walk time and public transport access (Figure 22):

- 2.7% of those living in 'rural village and dispersed' areas are more than a 15-minute drive from a pharmacy or dispensing GP practice.
- 89.1% of those living in 'rural village and dispersed' areas in Leicestershire are more than a 15-minute walk from a pharmacy or dispensing GP practice.
- 62.2% of those in 'rural village and dispersed' areas in Leicestershire are more than a 15-minute public transport journey on a weekday morning from a pharmacy or

dispensing GP practice.

Figure 22 Equality of access by rural/urban classification – walk and public transport times

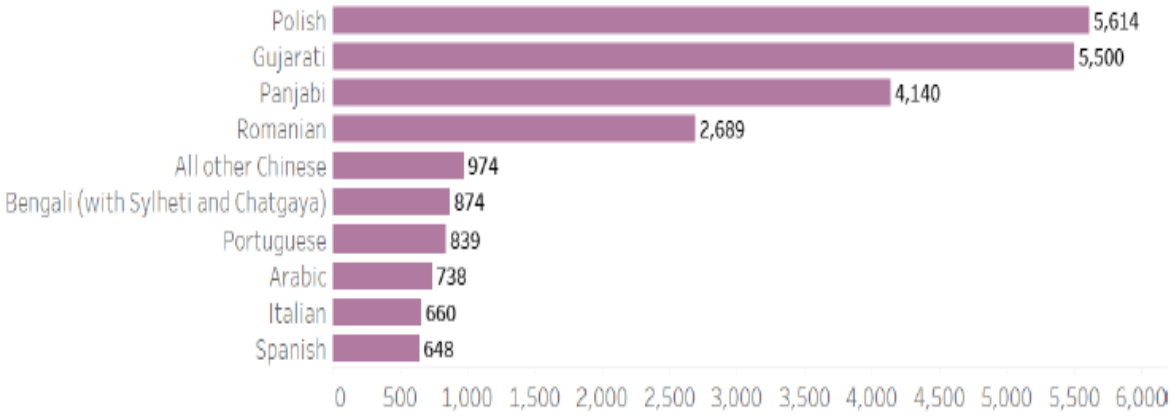


Source: Strategic Health Asset Planning and Evaluation (SHAPE) 2024

Language

In 2021(Census 2021), the main second language spoken in Leicestershire was Polish (5.6 thousand residents), followed by Gujarati (5.5 thousand) and Panjabi (4.1 thousand) (Figure 23).

Figure 23 Main language of non-English speaking population of Leicestershire



Source: ONS Census 2021

The highest proportion of non-English speakers was in Oadby and Wigston (10.1% of population) where Panjabi and Gujarati were the second and the third main spoken languages.

There was also a relatively high proportion of non-English speakers in Charnwood (6.7%) and Blaby (5.3%). In these two districts Gujarati and Polish, and Panjabi and Polish were most common second and third languages (Table 16).

In the remaining districts, less than 3% of the population were non-English speakers.

Table 16 Second and third languages spoken in Leicestershire districts (Census 2021)

District	English (%)*	2nd Main Language (%)		3rd Main Language (%)	
Blaby	94.70%	Panjabi	1.09%	Polish	0.93%
Charnwood	93.30%	Gujarati	1.65%	Polish	0.73%
Harborough	97.20%	Gujarati	0.38%	Panjabi	0.35%
Hinckley & Bosworth	97.20%	Polish	0.75%	Romanian	0.36%
Melton	97.10%	Polish	1.51%	Romanian	0.16%
North West Leicestershire	97.00%	Polish	1.16%	Romanian	0.43%
Oadby & Wigston	89.90%	Panjabi	3.00%	Gujarati	2.27%

* Proportion of population with English as main language

6.3.7. Cross Border Provision

The population of Leicestershire can access any pharmacy services, whether from community or distance selling provider. The choice can be dictated by proximity to the place of work rather than residence, thus it is important to take into account cross-border provision. Leicestershire borders with a number of health areas, including Leicester, Rutland, Lincolnshire, Northamptonshire, Warwickshire, Derbyshire and Nottinghamshire (Figure 24).

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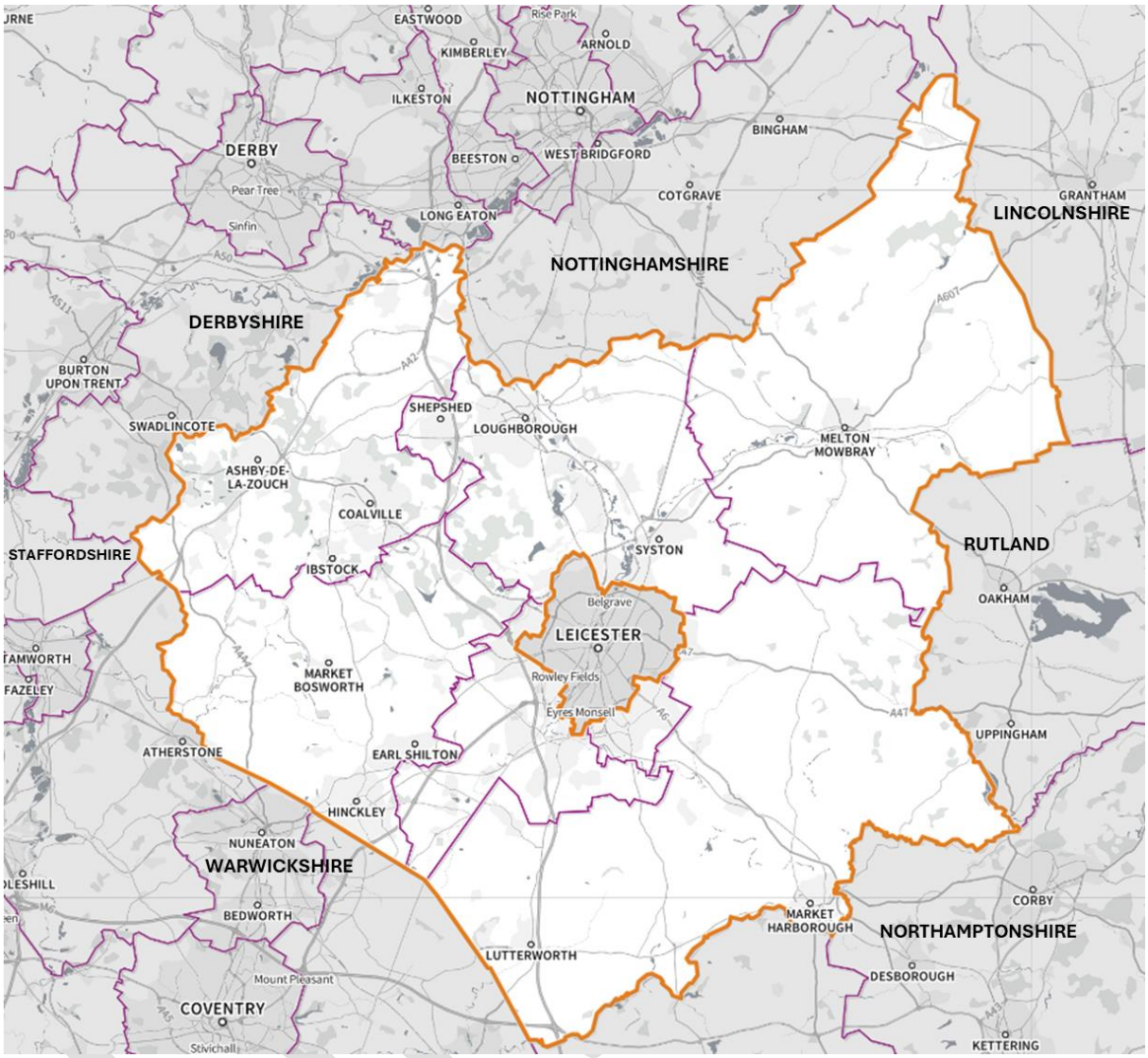
Figure 24 Neighbouring local authorities



Leicester

Leicester borders with the four of Leicestershire districts - Blaby, Oadby and Wigston, Harborough and Charnwood. There are significant population flows between Leicestershire and Leicester City (e.g. work or education) with many county residents accessing services in the city and vice-versa. The draft 2025 PNA for Leicester states that no significant gaps in pharmaceutical services were detected, with higher rates of provision per head of population than England's average. However, some of the city areas have fewer pharmacies (North West and West localities) and projected pharmacy closures could have further impact on accessibility of pharmacy services. Thus, continuous engagement and joint planning (LLR-wide) are needed to ensure equity of pharmaceutical service provision.

Rutland

Leicestershire districts of Harborough and Melton border with Rutland and both Counties are within the same ICB location, with Leicester City. Rutland residents are likely to use Leicestershire pharmacies, while a relatively small area in the east of Leicestershire may access pharmacies located in Rutland. The three pharmacies in Oakham are within easy reach from the southern parts of Melton district, and two Uppingham pharmacies can provide services for the eastern parts of the district of Harborough.

The draft 2025 PNA for Ruland states that no gaps in pharmaceutical services were detected, although continuous engagement is needed to maintain accessibility in rural areas of the County.

Lincolnshire

Lincolnshire borders with Melton District. The north-east areas of the district, particularly those close to the border, have 10+ pharmacies in Grantham within 10km of the district's border, Grantham being shorter distance than Melton Mowbray town itself.

The draft 2025 Lincolnshire PNA[19] states that the existing evidence does not identify any gaps in the provision of necessary services through community pharmacies and there is no current or future need for improved access to necessary services within existing community pharmacies in any District of Lincolnshire.

Northamptonshire

Northamptonshire borders with the Harborough district. Pharmacies in Corby (14+) are relatively easy access for the residents of Harborough district (within 7 km of the district's border).

Awaiting draft PNA.

Warwickshire and Coventry

Warwickshire borders with North West Leicestershire, Hinckley and Bosworth, Blaby, and Harborough districts.

There are several locations within Warwickshire which could potentially service Leicestershire residents, all within 8 km from Leicestershire borders, including Rugby (11 pharmacies), Nuneaton, Atherstone or Tamworth.

Awaiting draft PNA.

Staffordshire

Staffordshire has a relatively short border with North West Leicestershire.

Awaiting draft PNA.

Derbyshire and Derby

Derbyshire borders with North West Leicestershire, and there are several locations with pharmacies within relatively easy reach for its residents (within 8 km from the district border) – includes Swadlincote (six pharmacies), Burton-on-Trent (nine) and potentially parts of the city of Derby (14 pharmacies within 8 km radius).

Awaiting draft PNA.

Nottinghamshire

Nottinghamshire borders with North West Leicestershire, Charnwood and Melton. Leicestershire residents can access a numbers of pharmacies in locations adjacent to Nottingham, such as Long Eaton (nine pharmacies) or Stapleford.

The draft Nottinghamshire PNA 2025 concludes that there are no identified gaps in provision of NHS Necessary Services to meet current and future needs of the population. This includes provision during working and non-working hours. Similarly, no gaps in the provision of Advanced or Enhanced Services are reported that would secure improvements or better access to services in Nottinghamshire.

6.4. Essential Services

Essential services are mandatory, they are required of all community pharmacies within the NHS Community Pharmacy Contractual Framework (CPCF) 20.

Core Functions encompass the fundamental tasks of a pharmacy, including:

1. **Dispensing medicines and medical appliances** - the supply of medicines and appliances ordered on NHS prescriptions, together with information and advice, to enable safe and effective use by patients and carers, and maintenance of appropriate records.
2. **Repeat dispensing**, including electronic repeat dispensing (**eRD**) - management and dispensing of repeatable NHS prescriptions for medicines and appliances, in partnership with the patient and the prescriber. The service specification for repeat dispensing covers the requirements additional to those for dispensing, such that the pharmacist ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.
3. **Discharge Medicines Service (DMS)** - service was introduced in 2021 and aims to reduce the risk of medication problems when a person is discharged from hospital. Patients are digitally referred to their pharmacy after discharge from hospital.
4. **Disposal of unwanted medicines** - acceptance of unwanted medicines by someone living at home, in a children's home or in a residential care home which require safe

disposal.

5. **Promoting healthy lifestyles** - provision of opportunistic healthy lifestyle advice and public health advice to patients receiving prescriptions who appear to have, or be at risk of, certain conditions, e.g. diabetes or coronary heart disease; and participating in health campaigns where requested.
6. **Clinical governance** - pharmacies must have an identifiable clinical governance lead and apply clinical governance principles to the delivery of services (use of standard operating procedures; recording, reporting and learning from adverse incidents; participation in continuing professional development and clinical audit; and assessing patient satisfaction).
7. **Support for self-care** - provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.
8. **Signposting to other services** - provision of information on other health and social care providers or support organisations to people visiting the pharmacy who require further support, advice or treatment which cannot be provided by the pharmacy.

6.4.1. Discharge Medicines Service (DMS)

DMS became a new Essential service within the Community Pharmacy Contractual Framework (CPCF) on 15th February 2021 (2020/21 Q4).

This service was introduced to reduce the risk of medication problems when a person is discharged from hospital. Patients are digitally referred to their pharmacy after discharge from hospital. Using the information in the referral, pharmacists are able to compare the patient's medicines at discharge to those they were taking before admission to hospital. A check is also made when the first new prescription for the patient is issued in primary care and a consultation with the patient and/or their carer will help to ensure that they understand which medicines the patient should now be using.

There has been a significant rise in the number of claims for this service in Leicestershire between 2021/22 and 2023/24 - activity more than doubled overall (a 132% increase), and about three-fold in Blaby, and Oadby and Wigston (Table 17). Although the data are only for half of 2024/25, it appears that activity has risen even further in the current financial year.

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Table 17 Discharge Medicine Service claims in Leicestershire (complete and incomplete).

	2021/22	2022/23	2023/24	2024/25 (Q1-2)	Change*
Blaby	285	340	853	791	199%
Charnwood	403	501	1033	971	156%
Harborough	87	95	225	264	159%
Hinckley & Bosworth	310	264	540	491	74%
Melton	128	129	186	171	45%
NW Leicestershire	346	382	721	638	108%
Oadby & Wigston	66	100	214	217	224%
Leicestershire	**1,625**	**1,811**	**3,772**	**3,543**	**132%**

* between 2021/22 and 2023/24

6.5. Enhanced Services

In December 2021, provisions were made within the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 for a new type of Enhanced service, the **National Enhanced Service** (NES). Under this type of service, NHS England commissions an Enhanced Service that is nationally specified. There is currently one NES commissioned; this is the COVID-19 Vaccination Service.

6.5.1. COVID-19 Vaccination Service

The vaccination service was first commissioned as a Local Enhanced Service (LES) by NHS England regional teams in consultation with Local Pharmaceutical Committees. In December 2021, provisions were made within the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 for a new type of Enhanced service, the National Enhanced Service (NES), which is nationally specified. A NES allows the agreement of standard conditions nationally, while still allowing the flexibility for local decisions to commission the service to meet local population needs, as part of a nationally coordinated programme.

Between 1st of April 2023 and 31st of March 2024, 98,380 vaccinations were given by 47 participating Leicestershire pharmacies (Table 18). The vaccinations were assigned to localities by postcode of pharmacy location, which may not reflect the population coverage, particularly for pharmacies close to district boundaries.

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Table 18 COVID-19 vaccinations in 2023/24 – pharmacies located in Leicestershire

	Pharmacies	Vaccinations
Blaby	10	10,117
Charnwood	11	33,225
Harborough	6	15,897
Hinckley and Bosworth	9	18,220
Melton	3	9,009
North West Leicestershire	4	8,669
Oadby and Wigston	4	3,243
LEICESTERSHIRE	**47**	**98,380**

Source: ??? (LLR Patient Care Locally)

Phase 5 of the vaccination service, the Autumn 2022, Spring 2023, Autumn/Winter 2023/24 and Spring 2024 booster programmes were all commissioned as a NES.

For the **2025 Spring and Summer vaccination campaign** – 78 Leicestershire pharmacies are reported as 'active'7 – 13 out of 21 total in Blaby, 25/43 in Charnwood, 9/13 in Harborough, 13/18 in Hinckley and Bosworth, 4/9 in Melton 6/16 in North West Leicestershire and 8/12 in Oadby and Wigston. The cohorts for the spring 2025 programme covers adults aged 75 years and over, residents in a care home for older adults, and individuals aged 6 months and over who are immunosuppressed.

6.6. Advanced Services

Advanced services are optional, pharmacies can choose to offer these services, provided they meet specific requirements. They are also specialized, requiring additional training or resources for pharmacists, and can include:

- Appliance use reviews
- Flu vaccinations
- Hypertension case-finding - identification and management of high blood pressure.
- New Medicine Service - supporting patients newly prescribed a medicine.
- Lateral Flow Device Service - testing for certain illnesses.
- Pharmacy Contraception Service (PCS) - provides contraception advice and service.
- Pharmacy First Services
- Smoking Cessation Service (SCS): Helps patients quit smoking.
- Community Pharmacist Consultation Service (CPCS): Allows referrals from other parts of the health system for urgent care needs.

[7] Source: SHAPE 2025

There are several Advanced Services within the NHS Community Pharmacy Contractual Framework (CPCF). Community pharmacies can choose to provide any of these services as long as they meet the requirements set out in the Secretary of State Directions.

The current list includes[21] appliance use reviews (AUR), flu vaccination, hypertension case-finding, new medicine (NMS), lateral flow device (LFD), pharmacy contraception (PCS), pharmacy first (PF), smoking cessation (SCS) and stoma customisation services.

A number of services have been discontinued; however, data are included here for clarity where historical trends are presented.

Data presented are from the **Clinical Services Statistics (Community Pharmacy England)** - https://cpe.org.uk/funding-and-reimbursement/nhs-statistics/clinical-services-statistics/ .

This site provides quarterly statistics for clinical services provided by community pharmacies in England from April 2021 onwards (available up to September 2024, at the time of writing). For the purpose of this report, data were aggregated and analysed at county and district levels.

In addition, where available, these are for the last Q3 of 2024/5 (October-December 2024) from local sources. At the time of writing, local data are **provisional** but is generally regarded as a minimum (likely to rise by another 10% when figures are finalised).

6.6.1. Access to Advanced Services

Of the 131 Leicestershire pharmacies, most signed up for blood pressure checks, eight out of ten for contraception services (same for the LFD service), while only a third signed up for smoking cessation services (Table 19).

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Table 19 Providers signed up to services in September 2024

	All	BP Checks		SCS		PCS		LFD	
	Num	Num	%	Num	%	Num	%	Num	%
Blaby	21	21	100%	9	43%	18	86%	16	76%
Charnwood	43	39	91%	13	30%	35	81%	36	84%
Harborough	13	13	100%	7	54%	12	92%	11	85%
Hinckley & Bosworth	18	18	100%	6	33%	15	83%	18	100%
Melton	9	8	89%	1	11%	7	78%	6	67%
NW Leicestershire	16	16	100%	3	19%	13	81%	11	69%
Oadby & Wigston	11	11	100%	3	27%	10	91%	11	100%
LEICESTERSHIRE	**131**	**126**	**96%**	**42**	**32%**	**110**	**84%**	**109**	**83%**

SCS = Smoking Cessation Service
PCS = Pharmacy Contraception Service
LFD = Lateral Flow Device Service

Appliance Use Reviews (AUR)

AURs can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. Alternatively, if appropriate, they can be provided by telephone or video consultation.

AURs should improve the patient's knowledge and use of any 'specified appliance' by establishing the way the patient uses the appliance and the patient's experience of such use; identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient; advising the patient on the safe and appropriate storage of the appliance; and advising the patient on the safe and proper disposal of the appliances that are used or unwanted.

There are no data on AURs since 2020/21 either at the premises or in the patient's home.

Flu Vaccination Service

The aim of the seasonal influenza vaccination programme is to protect those who are most at risk of serious illness or death should they develop influenza, by offering protection against the most prevalent strains of influenza virus. Each year from the autumn through to March, the NHS runs a seasonal flu vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus.

Community pharmacy has been providing flu vaccinations under a nationally commissioned service since September 2015. The accessibility of pharmacies, their extended opening hours and the option to walk in without an appointment have proved popular with patients seeking vaccinations. Pharmacy owners are encouraged to proactively offer influenza vaccination to any

patient they identify as being eligible to receive it should the patient present in the pharmacy for any reason.

Table 20 presents the numbers of flu vaccinations for the recent quarters.

Table 20 Flu vaccination claims in Leicestershire (none prior to 2023/4)

	2023/24				2024/25		
	Q1	Q2	Q3	Q4	Q1	Q2	2023/4 Total
Blaby	-	2,600	5,265	41	-	2	7,906
Charnwood	-	5,914	12,306	171	-	12	18,391
Harborough	-	3,003	6,774	168	-	0	9,945
Hinckley & Bosworth	-	2,263	4,596	38	-	2	6,897
Melton	-	1,053	2,010	28	-	0	3,091
NW Leicestershire	-	2,644	4,508	47	-	1	7,199
Oadby & Wigston	-	1,362	2,950	49	-	0	4,361
Leicestershire		**18,839**	**38,409**	**542**		**17**	**57,790**

Hypertension Case-Finding Service

The service, also referred to as NHS Blood Pressure Check Service (BPCS), was commissioned as an Advanced Service from 1st October 2021. The aim of the service is to prevent cardiovascular disease (CVD) and related mortality, as well as positively impact health inequalities in the population. CVD is a key driver of health inequalities, accounting for around 25% of the life expectancy gap (27% in men and 24% in women) between rich and poor populations in England.

The service aims to:

- Identify people aged 40 years or older, or at the discretion of pharmacy staff, people under the age of 40, with high blood pressure (who have previously not had a confirmed diagnosis of hypertension), and to refer them to general practice to confirm the diagnosis and for appropriate management
- At the request of a general practice, undertake ad hoc clinic and ambulatory blood pressure measurements (ABPM). These requests can be in relation to people either with or without a diagnosis of hypertension; and
- Provide another opportunity to promote healthy behaviours to patients.

In Leicestershire, there has been a steady increase in BP checks – from under 17 thousand in 2022/23 to over 31 thousand in 2023/24. Given only three quarters of data for 2024/25, the

forecast could be over 44 thousand for the current year (Table 21). In March 2025, 125 pharmacies were signed up to provide this service.

Table 21 Hypertension case finding service through clinic BP checks and ambulatory blood pressure monitoring (ABPM) in Leicestershire

Clinic BP Checks	2021/22	2022/23	2023/24	2024/25			Change**
				Q1	Q2	Q3*	
Blaby	3,076	5,227	6,277	1,624	1,807	2,005	39%
Charnwood	764	4,075	8,556	3,115	3,232	3,008	206%
Harborough	149	1,909	4,941	1,536	1,427	1,787	232%
Hinckley & Bosworth	404	1,559	2,124	638	925	408	69%
Melton	71	949	1,782	861	984	1,264	337%
NW Leicestershire	225	1,206	3,957	1,582	1,255	986	323%
Oadby & Wigston	153	1,305	2,342	1,211	1,208	1,094	259%
Leicestershire	**4,842**	**16,230**	**29,979**	**10,567**	**10,838**	**10,552**	**163%**

ABPM	2021/22	2022/23	2023/24	2024/25			Change**
				Q1	Q2	Q3*	
Blaby	36	255	389	98	129	139	91%
Charnwood	22	122	146	72	95	152	249%
Harborough	17	10	145	24	55	45	1,553%
Hinckley & Bosworth	9	81	104	49	55	40	137%
Melton	2	9	47	27	48	23	1,352%
NW Leicestershire	25	146	283	117	118	93	200%
Oadby & Wigston	1	20	81	41	50	52	853%
Leicestershire	**112**	**643**	**1,195**	**428**	**550**	**544**	**216%**

* provisional local data
**average quarterly number in 2024/25 vs average quarterly in 2022/23

New Medicine Service (NMS)

This service was introduced on 1st October 2011. The service provides support for people with long term conditions who have been newly prescribed a medicine to help improve medicines adherence and self-manage their condition. This service is initially focused on particular patient groups and conditions.

Sub-optimal medicines' use can lead to inadequate management of long-term conditions and non-adherence to appropriately prescribed medicines is a global health problem of major relevance to the NHS. Pharmacists can successfully intervene when a medicine is newly prescribed, with repeated follow up in the short term, to increase effective medicine taking for the treatment of a long-term condition.

The service is usually delivered in three stages, starting with patient engagement (new medicine dispensed as usual, with the provision of advice about its use, and the patient offered the opportunity to use the NMS), intervention (advice and assessment of adherence, and any other support required) and follow up – using an interview schedule.

In Leicestershire the volume of the service has almost doubled between 2021/22 and 2023/24, from 29.7 thousand claims to over 59 thousand. Given the numbers recorded in the first two quarters of the current financial year, the trend is likely to increase further. The biggest relative increase was in Harborough (more than three-fold) and North-West Leicestershire (three-fold) (Table 22).

Table 22 New Medicines Service in Leicestershire

	2021/22	2022/23	2023/24	2024/25 (Q1-2)	Change*
Blaby	4,943	6,194	9,756	5,783	97%
Charnwood	8,502	10,441	14,300	9,085	68%
Harborough	2,238	3,749	7,432	5,038	232%
Hinckley & Bosworth	5,762	6,572	8,324	5,113	44%
Melton	1,805	2,345	3,173	2,084	76%
NW Leicestershire	3,763	7,466	11,197	6,438	198%
Oadby & Wigston	2,615	3,653	4,884	3,613	87%
Leicestershire	**29,628**	**40,420**	**59,066**	**37,154**	**99%**

* percentage change between 2021/22 and 2023/24

Lateral Flow Device (LFD) Service

The Lateral flow device tests supply service for patients potentially eligible for COVID-19 treatments (LFD service) was commissioned as an Advanced Service from 6th November 2023.

In March 2024 it was announced that the service would continue to be commissioned in 2024/25 and that additional patient groups became eligible to access the service, with further updates in May 2024[22].

The NHS offers COVID-19 treatment to people with COVID-19 who are at risk of becoming seriously ill. The LFD service was introduced to provide eligible patients with access to LFD tests. If a patient tests positive, they are advised to call their general practice, NHS 111 or hospital specialist as soon as possible.

A similar service was previously commissioned, which was known as the **COVID-19 Lateral Flow Device Distribution Service** (publicly known as Pharmacy Collect). However, that service was decommissioned on 31st March 2022.

In Leicestershire, 83% of providers sign up to this service, with almost 2.4 thousand claims

between July and September 2024 (approximately 800 per month) (Table 23).

Table 23 Lateral Flow Device Services in Leicestershire – quarterly claim totals

	2023-24		2024-25	
	Q3	Q4	Q1	Q2
Blaby	-	482	544	692
Charnwood	-	564	675	445
Harborough	-	169	158	209
Hinckley & Bosworth	-	86	107	82
Melton	-	272	504	422
NW Leicestershire	-	56	91	487
Oadby & Wigston	-	36	35	42
Leicestershire	**-**	**1,665**	**2,114**	**2,379**

Pharmacy Contraception Service (PCS)

The PCS commenced on 24th April 2023, allowing the on-going supply of oral contraception (OC) from community pharmacies. From 1st December 2023, the service expanded to include both initiation and on-going supply of OC.

The service also provides an opportunity for signposting service users into local sexual health services in line with NICE guideline NG 10223.

A majority (84%) of local contractors signed up to the PCS service (Table 19) and about 700 of claims are submitted monthly (Table 24), with increasing rates of services across all districts.

Table 24 Pharmacy Contraception Services (PCS) in Leicestershire

	2023-24		2024-25			Change**
	Q3	Q4	Q1	Q2	Q3*	
Blaby	-	104	296	359	436	4.2
Charnwood	-	243	298	287	432	1.8
Harborough	-	15	107	148	212	14.1
Hinckley & Bosworth	-	135	204	317	382	2.8
Melton	-	20	52	85	101	5.1
NW Leicestershire	-	262	455	484	486	1.9
Oadby & Wigston	-	35	56	81	131	3.7
Leicestershire	**-**	**814**	**1,468**	**1,761**	**2,180**	**2.7**

* local data (provisional)
**Q3 2024/25 vs Q4 2023/24

Pharmacy First Service

The NHS Pharmacy First Service incorporates the previous Community Pharmacist Consultation Service and builds on it to enable community pharmacy to complete episodes of care for seven common conditions following specific clinical pathways. It enables the management of common infections by community pharmacies through offering self-care, safety-netting advice, and supplying certain over the counter and prescription only medicines via clinical protocol and patient group directions.

Pharmacy First Service commenced on **31st January 2024**. It was announced as part of an agreement setting out how the £645 million investment pledged within the Delivery Plan for recovering access to primary care would be used to support community pharmacy services.

The Advanced Service involves pharmacists providing advice and NHS-funded treatment, where clinically appropriate, for seven common conditions (age restrictions apply):

- Sinusitis (12 years and over)
- Sore throat (5 years and over)
- Acute otitis media (1-17 years)
- Infected insect bite (1 year and over)
- Impetigo (1 year and over)
- Shingles (18 years and over)
- Uncomplicated UTI (women 16-64 years)

Consultations for these seven clinical pathways can be provided to patients presenting to the pharmacy as well as those referred electronically by NHS 111, general practices and others.

The service also incorporates the elements of the **Community Pharmacist Consultation Service**, i.e. **minor illness consultations** with a pharmacist and the **supply of urgent medicines** (and appliances), both following an electronic referral from NHS 111, general practices (urgent supply referrals are not allowed from general practices) and other authorised healthcare providers (i.e. patients are not able to present to the pharmacy without an electronic referral).

In the clinical pathway consultations with a pharmacist, people with symptoms suggestive of the seven conditions will be provided with advice and will be supplied, where clinically necessary, with a prescription-only treatment under a Patient Group Direction (PGD) or in one pathway, an over-the-counter medicine (supplied under a clinical protocol), all at NHS expense.

Currently, all pharmacists providing the service must use the PGDs and clinical protocol.

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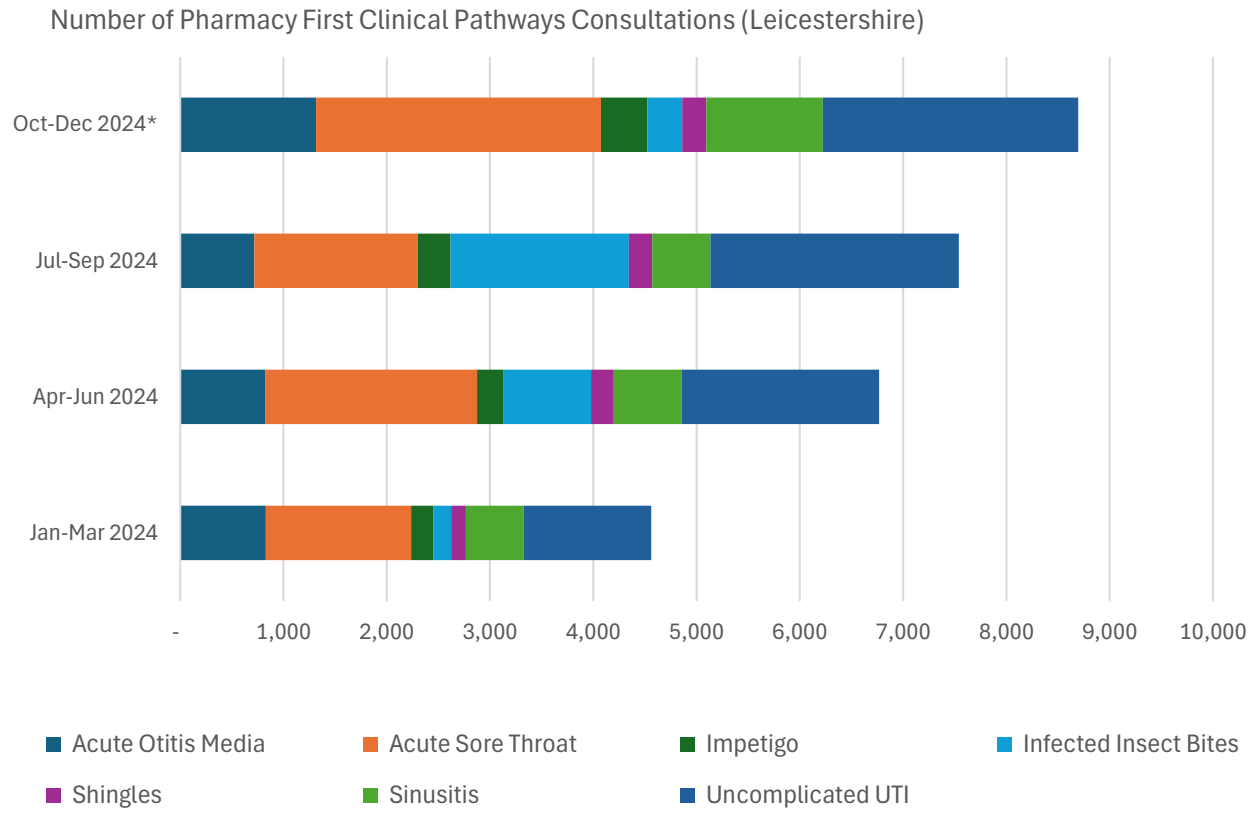
Table 25 Pharmacy First Services in Leicestershire - total number of claims

PF Total	2023-24		2024-25			Change**
	Q3	Q4	Q1	Q2	Q3*	
Blaby	-	1,242	1,710	1,692	1,932	1.6
Charnwood	-	705	1,354	1,553	1,982	2.8
Harborough	-	932	1,318	1,441	1,486	1.6
Hinckley & Bosworth	-	588	803	1,001	1,197	2.0
Melton	-	192	252	293	264	1.4
NW Leicestershire	-	628	831	991	1,086	1.7
Oadby & Wigston	-	273	499	569	750	2.7
Leicestershire	**-**	**4,560**	**6,767**	**7,540**	**8,697**	**1.9**

* local data (provisional)
**Q3 2024/25 vs Q4 2023/24

Figure 25 below shows quarterly patterns by condition – there is an overall increase in consultations with some understandable seasonal fluctuations.

Figure 25 PF consultations in Leicestershire by condition



* local data (provisional)

Table 26 Pharmacy First - minor illness consultations in Leicestershire

Minor Illness	2023-24		2024-25			Change**
	Q3	Q4	Q1	Q2	Q3*	
Blaby	-	1,500	2,241	1,387	1,881	1.3
Charnwood	-	732	741	480	802	1.1
Harborough	-	302	283	223	152	0.5
Hinckley & Bosworth	-	534	434	280	387	0.7
Melton	-	224	271	147	213	1.0
NW Leicestershire	-	475	674	512	533	1.1
Oadby & Wigston	-	409	440	361	791	1.9
Leicestershire	**-**	**4,176**	**5,084**	**3,390**	**4,759**	**1.1**

* local data (provisional)
**Q3 2024/25 vs Q4 2023/24

Table 27 Pharmacy First – supply of urgent medicines and appliances in Leicestershire

Urgent medical	2023-24		2024-25			Change**
	Q3	Q4	Q1	Q2	Q3*	
Blaby	-	213	337	340	485	2.3
Charnwood	-	406	697	781	905	2.2
Harborough	-	238	350	482	441	1.9
Hinckley & Bosworth	-	145	297	325	357	2.5
Melton	-	75	132	173	197	2.6
NW Leicestershire	-	147	218	233	273	1.9
Oadby & Wigston	-	203	377	378	315	1.6
Leicestershire	**-**	**1,427**	**2,408**	**2,712**	**2,973**	**2.1**

* local data (provisional)
**Q3 2024/25 vs Q4 2023/24

Almost all pharmacies in Leicestershire provide this service - In January 2025, only two pharmacies in Leicestershire were listed as not providing Pharmacy First (one in North West Leicestershire and one in Charnwood)[8].

Smoking Cessation Service (SCS)

In 2020/21 a Pharmacy Integration Fund pilot on smoking cessation began to test a new model

[8] Source: SHAPE April 2025

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of working in which community pharmacies managed the continuing provision of smoking cessation support initiated in secondary care following patient discharge from hospital.

The early findings from the pilot indicated that a consistent, national offer could be achieved through community pharmacy, and that it could create the capacity needed to enable NHS trusts to transfer patients for smoking cessation support into the community. The SCS was therefore added to the NHS Community Pharmacy Contractual Framework (CPCF) as part of Year 3 (2021/22) of the five-year CPCF deal.

This service has been designed to enable NHS trusts to undertake a transfer of care on patient discharge, referring patients (where they consent) to a community pharmacy of their choice to continue their smoking cessation treatment, including providing medication and support as required. The ambition is for referral from NHS trusts to community pharmacy to create additional capacity in the smoking cessation pathway. The service can only be provided by a pharmacist or a pharmacy technician.

The numbers recorded for this service in Leicestershire are low - 2 in 2022/23, 41 in 2023/24 and 38 in 2024/25 (first two quarters only).

Stoma Customisation (SAC)

The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.

The rates of SAC services have been reducing across Leicestershire, from 131 in 2021/22 to 49 in 2023/24. In the first half of 2024/25 there were just 19 SAC consultations reported (Table 28).

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Table 28 Stoma Appliance Customisation services in Leicestershire - annual

	2021/22	2022/23	2023/24	2024/25 (Q1-2)
Blaby	24	18	4	-
Charnwood	58	48	38	19
Harborough	13	10	3	-
Hinckley & Bosworth	8	1	-	-
Melton	6	6	1	-
NW Leicestershire	12	6	1	-
Oadby & Wigston	10	9	2	-
Leicestershire	**131**	**98**	**49**	**19**

6.6.2. Discontinued/decommissioned Services

C-19 Lateral Flow Distribution Service

This service was decommissioned on 31st March 2022

Community Pharmacist Consultation Service (CPCS)

Introduced in November 2020 this service replaced the NHS Urgent Medicine Supply service pilot. General practices and NHS 111 could refer patients for minor illness consultation at pharmacies offering CPCS. Pharmacy First replaced this service on 31st January 2024 therefore the data for this service goes up to this point.

The historical volume of the service in Leicestershire is presented below as comparison to the new Pharmacy First Service. The rates were rising steadily between 2021/2 and 2023/24. In 2023/24 there were over 23.9 thousand consultations in Leicestershire (plus 4.5 thousand PF consultations); this is comparable to 14.2 thousand PF consultations in the first half of 2024/25 (Table 29).

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Table 29 Historical trends in CPCS in Leicestershire

CPSC	2021/22	2022/23	2023/24
Blaby	3,834	5,970	8,946
Charnwood	1,801	2,885	3,808
Harborough	872	987	1,810
Hinckley & Bosworth	1,483	2,039	2,365
Melton	723	1,223	1,148
NW Leicestershire	1,519	4,333	3,749
Oadby & Wigston	1,160	1,306	2,088
Leicestershire	**11,392**	**18,743**	**23,914**

Hepatitis C Testing Service

This service was decommissioned on 31st March 2023.

There were no data recorded for Leicestershire for this service since 2021/22.

Pandemic Delivery Service

This service was decommissioned on 31st March 2022.

6.7. Quality Assurance

In England, the quality of community pharmacies is assured through the Pharmacy Quality Scheme (PQS) and the Community Pharmacy Assurance Framework (CPAF), which form parts of the Community Pharmacy Contractual Framework (CPCF) and are designed to reward pharmacies that deliver quality criteria in clinical effectiveness, patient safety and patient experience.

The Pharmacy Quality Scheme (PQS) supports delivery of the NHS Long Term Plan and rewards community pharmacy contractors who deliver quality criteria in three quality dimensions: clinical effectiveness, patient safety and patient experience24. NHS England, in collaboration with internal and external stakeholders, develops the PQS annually, with the most recent document replacing guidance issued for all previous schemes.

At the time of writing, the latest edition available is that for 2023/24, with 2024/25 still under negotiation. It consists of one gateway criterion and three quality domains. Each domain within the PQS has a designated maximum number of points. Ther gateway criterion is at least 15 New Medicine Service (NMS) consultations, there are also two quality criteria for the medicines' safety and optimisation domain, five for respiratory domain, and one for the prevention domain.

NHS England's regional teams use the **Community Pharmacy Assurance Framework (CPAF)** to monitor community pharmacy owners' compliance with the terms of the Community Pharmacy Contractual Framework (CPCF). They have the responsibility for monitoring the provision of Essential and Advanced services. Arrangements for monitoring locally commissioned services may be set out in local contracts or Service Level Agreements.

As a result of NHS regulations introduced at the end of 2020, contractors must complete the screening questionnaire within the required time period each year and, if required, the full CPAF questionnaire.

6.8. Locally Commissioned Services (LCS)

These include additional services that are commissioned locally, usually by the NHS or local authority, to meet the specific health needs of local populations. A number of these services are commissioned from community pharmacies.

The services that are currently commissioned by Leicestershire County Council are:

- Emergency Hormonal Contraception (EHC)
- Needle and syringe exchange for people with drug addictions (via Turning Point)
- Supervised administration of methadone and other substitutes (via Turning Point)
- Take Home Naloxone Programme
- H. Pylori C13 Urea Breath Test Service – Leicester only
- Urgent Supply and Home Delivery of Palliative Care and Specialised Medicines

The numbers of pharmacies signed up to provide LCS in 2024/25 are given in Table 30.

Table 30 Number of pharmacies providing locally commissioned services in 2024/25

District	Take Home Naloxone	Needle Exchange	Supervised Consumption	EHC
Blaby	-	3	10	4
Charnwood	2	4	21	7
Harborough	-	3	6	2
Hinckley and Bosworth	1	4	13	5
Melton	-	3	7	0
North-West Leicestershire	1	4	14	6
Oadby and Wigston	-	2	8	4
LEICESTERSHIRE	**4**	**23**	**79**	**28**

Source: Turning Point 2025

6.8.1. Emergency Hormonal Contraception (EHC)

Although currently commissioned by the local authority (Leicestershire County Council), from October 2025, EHC is expected to be added to the advanced, nationally commissioned, Pharmacy Contraception Service (PCS) (See 6.6, page 62).

The service is for the provision of free Emergency Hormonal Contraception (EHC) to women in the community pharmacy setting. This is combined with sexual health advice aiming to:

- improve access to emergency contraception, safer sex and sexual health advice,
- reduce the number of unintended pregnancies in the client group by use of EHC.
- refer all clients accessing this service into mainstream contraceptive services for ongoing contraceptive needs.
- increase the knowledge of risks associated with sexually transmitted infections (STIs).
- refer clients at risk of STIs to an appropriate service; and
- increase knowledge, especially among young people, of the availability of EHC from the community pharmacy setting.

Services include the provision of levonorgestrel ('Levonelle'/'Ella') or ulipristal acetate (UPA), under a patient group direction (PGD), and consultation with a client. UPA can be effective up to 120 hours after unprotected sexual intercourse, while levonorgestrel up to 96 hours, although 17-96 hours use is off label (UPA preferred in such cases).

Time trends in **UPA supply** by Leicestershire pharmacies is shown in Table 31. The total annual numbers thus reduced slightly from around 700 in 2022/22 and 2022/23, to 631 in 2023/24. The 2024/25 data cover only the first three quarters of the current year, the total for the full year is estimated at approximately 615 (total for Leicestershire), expected to be even lower than in previous year.

Numbers for **levonorgestrel supply** have been reducing substantially, from 193 in 2020/21 to 54 in 2023/24 and an estimated total 50 for the whole of 2024/25 (Table 32).

Numbers of **consultations** also seem to be reducing - after relatively low numbers for 2020/21 (COVID-19 pandemic), from 873 consultation in 2021/22 down to estimated 670 for 2024/25 (Table 33).

Table 31 Time trends in pharmacy emergency UPA supply in Leicestershire

	2020/21	2021/22	2022/23	2023/24	2024/25*
Blaby	55	57	40	18	18
Charnwood	141	339	465	440	260
Harborough	39	19	0	1	0
Hinckley and Bosworth	53	56	54	60	55
Melton	1	0	0	0	0

North-West Leicestershire	66	67	44	63	49
Oadby and Wigston	69	157	104	49	49
Leicestershire	**424**	**695**	**707**	**631**	**431**

* April to December 2024 only

Source: Leicestershire County Council (Pharmoutcomes), 2025

Table 32 Time trends in pharmacy emergency levonorgestrel supply in Leicestershire

	2020/21	2021/22	2022/23	2023/24	2024/25*
Blaby	37	17	4	6	10
Charnwood	60	93	13	5	1
Harborough	9	2	2	2	0
Hinckley and Bosworth	17	8	3	10	9
Melton	1	0	0	0	0
North-West Leicestershire	21	21	12	11	4
Oadby and Wigston	49	27	32	20	11
Leicestershire	**194**	**168**	**66**	**54**	**35**

* April to December 2024 only

Source: Leicestershire County Council (Pharmoutcomes), 2025

Table 33 Time trends in pharmacy EHC client consultations in Leicestershire

	2020/21	2021/22	2022/23	2023/24	2024/25
Blaby	92	74	44	24	28
Charnwood	204	438	484	447	261
Harborough	49	21	2	3	0
Hinckley and Bosworth	70	67	57	71	66
Melton	2	0	0	0	0
North-West Leicestershire	88	88	57	74	53
Oadby and Wigston	119	185	137	70	61
Leicestershire	**624**	**873**	**781**	**689**	**469**

* April to December 2024 only

Source: Leicestershire County Council (Pharmoutcomes), 2025

Age and ethnicity

For the whole period (April 2020-December 2024), the majority of activity (88%) involved women over the age of 18, 9% (N=333) for those aged 16 to 17, and 3% (N=123) for those aged less than 16. Data are not presented for individual years, as numbers become small for some age groups. The highest proportion of under 16s was in Harborough (Figure 26). The highest rates for 18-20s were in Charnwood (most likely high numbers of university-age population).

For the same period, 72.6% (N=2,735) of patients were of white ethnicity, 12.5% were Asian or Asian British (N=469), 6% Black or Black British (N=225) and 3.2% of mixed ethnicity (N=121

(Figure 27).

Figure 26 Emergency hormonal contraception - age (April 2020-December 2024)

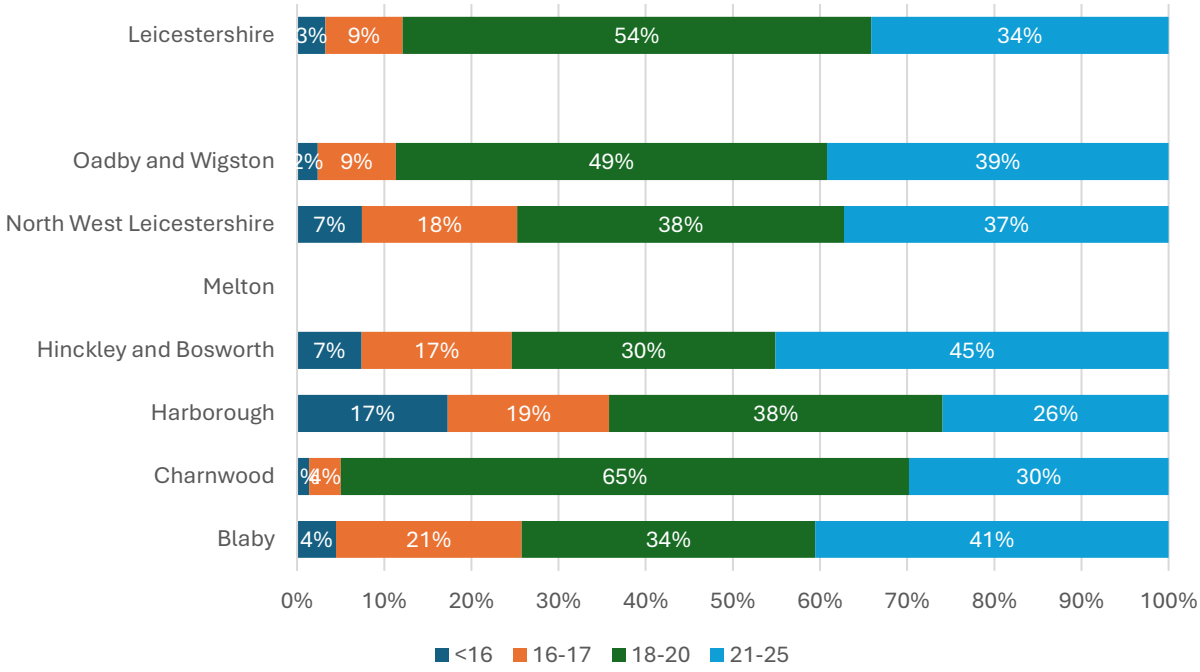
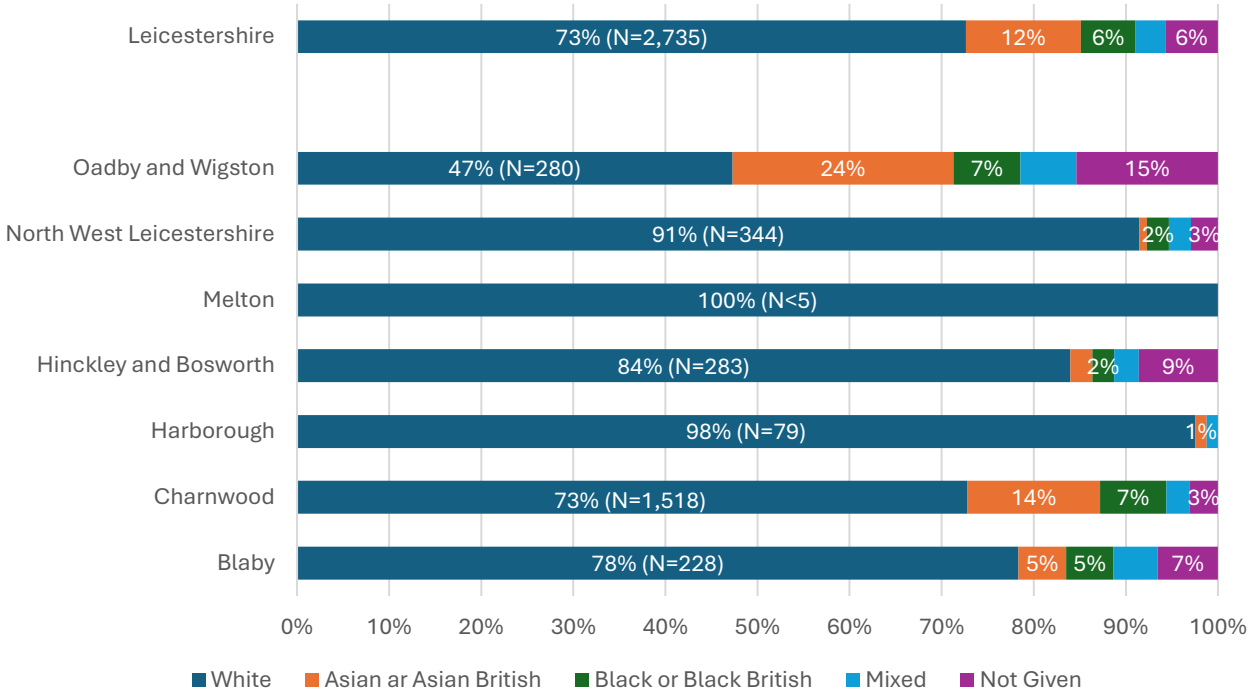


Figure 27 Emergency hormonal contraception - ethnicity (April 2020-December 2024)

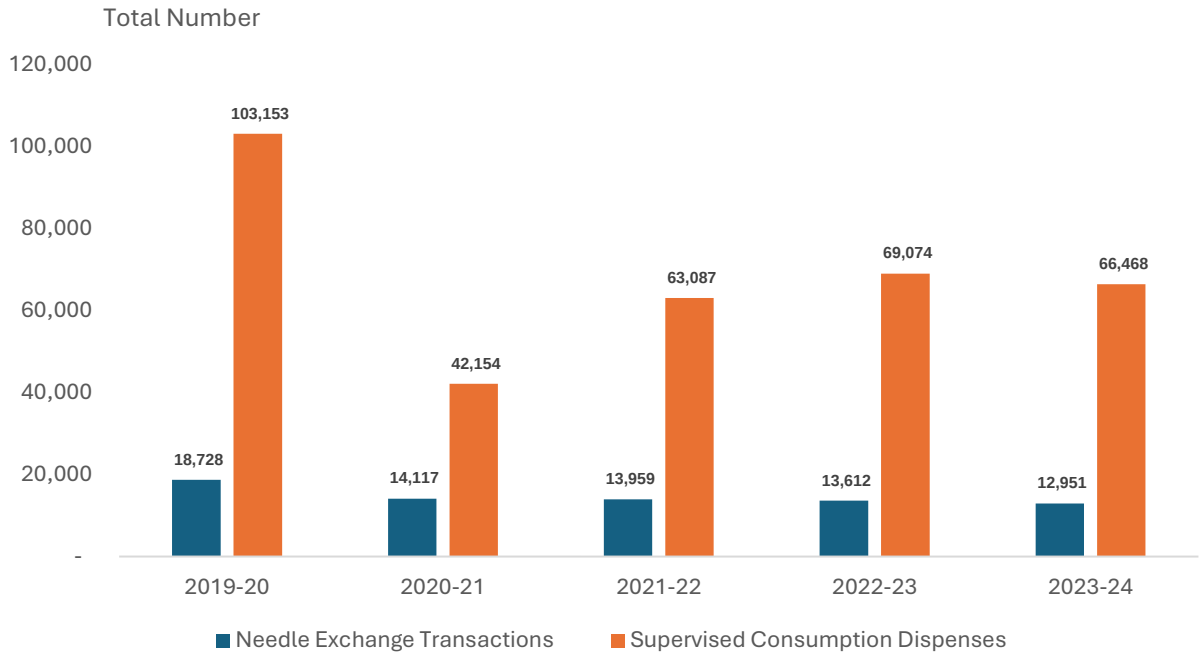


From October 2025, with the new CPCF, Emergency Hormonal Contraception will be added to

the Pharmacy Contraception Service (See 6.6, page 62).

6.8.2. Needle Exchange and Supervised Consumption

Figure 28 Overall trends in needle exchange and supervised consumption in Leicestershire



Source: Turning Point 2025

Supervised administration of methadone and other substitutes

There has been a reduction from over 103 thousand supervised consumption dispenses in 2019/20 to just under 66.5 thousand in 2023/24 across Leicestershire, with similar annual pattern across the districts (Table 34 and Figure 28).

Table 34 Supervised consumption dispenses 2019/20 to 2023/24 by district

District	2019-20	2020-21	2021-22	2022-23	2023-24
Blaby	7,892	3,437	5,787	6,024	6,057
Charnwood	37,787	18,707	27,259	30,153	28,435
Harborough	14,574	2,797	3,987	6,015	5,672
Hinckley and Bosworth	14,351	7,215	9,071	6,477	6,857
Melton	6,658	4,808	4,771	4,578	3,788
North-West Leicestershire	15,785	4,526	10,126	12,386	12,106
Oadby and Wigston	6,106	664	2,086	3,441	3,553
Leicestershire	103,153	42,154	63,087	69,074	66,468

Source: Turning Point 2025

Needle and syringe exchange for people with drug addictions

As for supervised consumption, there has been a reduction from over 18.7 thousand needle exchanges in 2019/20 to just under 13 thousand in 2023/24 across Leicestershire (Table 35 and Figure 28).

Table 35 Trends in needle exchange provision in Leicestershire districts

District	2019-20	2020-21	2021-22	2022-23	2023-24
Blaby	1,534	1,290	963	1,026	1,361
Charnwood	7,007	5,282	4,655	4,769	4,554
Harborough	1,818	967	1,258	1,318	851
Hinckley and Bosworth	1,938	1,101	1,635	1,625	1,435
Melton	5,494	4,833	4,917	4,279	4,019
North-West Leicestershire	622	482	463	538	685
Oadby and Wigston	315	162	68	57	46
Leicestershire	18,728	14,117	13,959	13,612	12,951

Source: Turning Point 2025

6.8.3. Take Home Naloxone Programme

Naloxone is a medicine which reverses the effects of opioid drugs like heroin and methadone (opioid antagonist). It is a first aid emergency medicine, available in the UK as an injection and as a nasal spray. In the UK, naloxone can be supplied without prescription by certain groups including pharmacy teams who provide opioid substitution therapy (e.g. methadone) or needle exchange. The law doesn't specify who it can be supplied to; guidance suggests supply should

include people who use drugs, family, friends and carers of people who use drugs, hostel staff and outreach workers. Naloxone can currently be administered by anyone in an emergency but can only legally be supplied without prescription by a drug and alcohol treatment service to a person to take home for future use.

Across England in 2023, a total of 2,551 drug-poisoning deaths involved opiates; this was 13% higher than in 2022. Nationally, the age-standardised rate of deaths involving an opiate has risen more than five-fold, from 8.4 per million population in 1993 to 43.8 in 2023.

In 2023/24, Leicestershire pharmacies dispensed naloxone 147 times (including 131 through Charnwood and 14 through North-West Leicestershire pharmacies), and 75 times between April and December 2025. Thus, figures for the current financial appear to be lower (predicted 115 for the full 2024/25, assuming 35% for the last quarter, as in 2023/24).

Four pharmacies provide this service – 2 in Charnwood, one in NWL and one in Hinckley and Bosworth.

6.8.4. H. Pylori Breath Test

Is currently provided by a number of LIPCO (Leicestershire Independent Pharmacy Company) pharmacies in the Leicester area only. Service is only commissioned for Leicester residents.

6.8.5. Palliative Care – Urgent Supply and Home Delivery

The service ensures rapid access to specified palliative pathway medicines, such as pain relief or antibiotics (oral and injection), for the LLR population. It includes delivery to the patient's address within three hours of receiving the prescription by the pharmacy, between 7 am and 11 pm Monday to Friday.

Between October 2020 and September 2024, 11 Leicestershire pharmacies held stock for the urgent supply and home delivery of palliative care and specialised medicines service (rising to 12 for a number of months). Trends in the number of dispensed items, at half-yearly intervals for all LLR pharmacies (classified by pharmacy location) is shown on Figure 29. It shows a fall in dispensed items from about 37 per month up to October 2021 (possibly reflecting COVID 19 restrictions) to a more stable average of 17 per month from October 2021. The majority of medicines were dispensed by Leicestershire pharmacies in that period.

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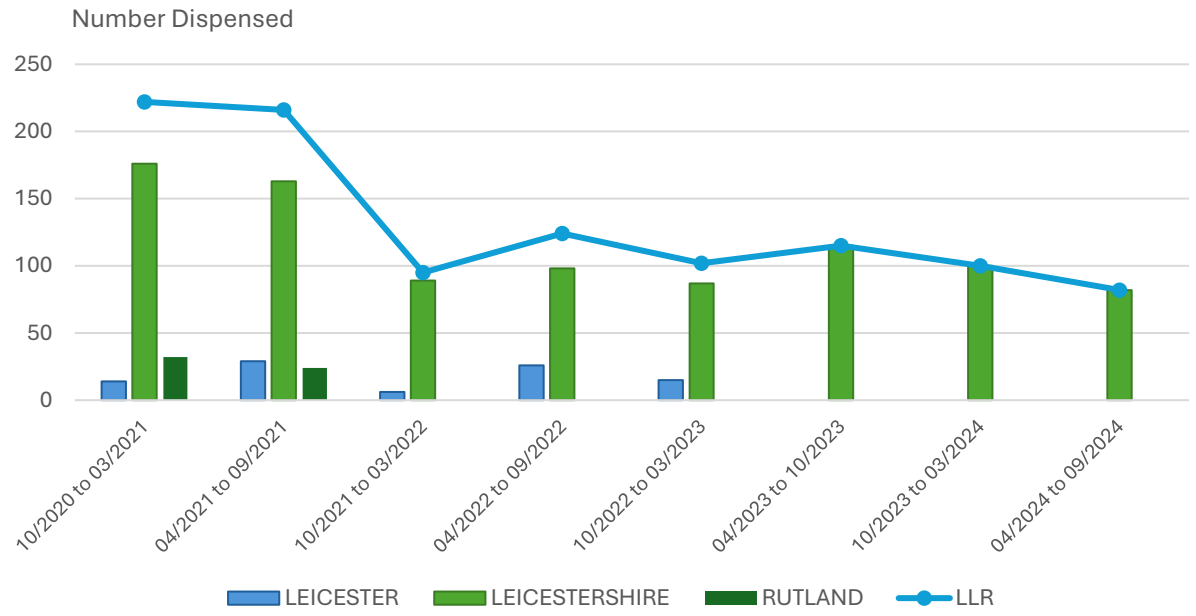
Figure 29 Past trends in palliative care dispensing activity across LLR pharmacies (October 2020 to September 2024)



Source: LLR ICB Medicines Optimisation 2025

The service was recommissioned in 2024, as a pilot for 2 years, and as result from October 2024 only one pharmacy in Leicester (**Omcare Late Night Pharmacy**) provides this service for all residents of Leicester, Leicestershire and Rutland. Omcare Pharmacy is open from 7am to 10pm Mon-Fri, and 7am to 8pm Sat, and 1am-7pm on Sunday. From data available, there were 58 deliveries of urgent end of life medications between 1st October - 17th March to Leicestershire residents.

6.9. CPCF Arrangements for 2024/25 and 2025/26

The new funding and other arrangements for community pharmacies were agreed in March 2025, giving community pharmacy a largest uplift in funding across the whole of NHS (a 30% when compared to 2023/24)[25]. The settlement recognises the key role of the community pharmacies in future health care, securing further funds for continuation of Pharmacy First and other Primary Care Recovery Plan services.

Upcoming changes include the addition of antidepressants to the New Medicine Service (NMS) and Emergency Hormonal Contraception (EHC, currently commissioned locally) to the nationally commissioned Contraception Service (planned for October 2025).

It also includes some regulatory changes such as more scope to amend core opening hours,

stopping NMS subcontracting, maximum of four health campaigns (incl. two from ICB) or DSPs no longer being able to provide Advanced or Enhanced services on their premises. The Pharmacy Quality Scheme (PQS) is to be smaller than usual in 2025/26, including elements from previous schemes to support embedding of quality improvements.

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7. Stakeholder Views

7.1. PNA Pharmacy Professional Survey

INTERIM RESULTS - The section will be reviewed and updated when full results, including the extension, are available.

This section summarises the results of the PNA Professional Survey which was run between 3rd of February to 4th of April 2025. The full results are available in the APPENDIX.

A total of **22 Leicestershire pharmacies** responded to the survey, with such a small sample size so far, the preliminary results have to be treated with caution. All responding pharmacies were community pharmacies, with the majority (82%) with more than five thousand enquiries per year.

Over a half (55%) of respondents said they felt able to maintain the **current level of service**, with 27% stating they did not. 41% of respondents stated that they planned to expand their business, while 41% planned to continue the same level of service. Only 5% planned to reduce the level of operation.

Judging the general **pharmaceutical services' provision** within 3-mile radius, nine out of ten respondents thought it was good or very good in terms of location, number of pharmacies and range of services provided.

64% of pharmacies had one **consultation** area, while 16% had two or more, all having wheelchair access and handwashing facilities in the room or close by. On average, pharmacies gave 34 consultations per week (range: 5-80). Almost a half (48%) of pharmacies planned to increase consultations in the next 12 months.

Of the **facilities** available to help people access services, most pharmacies (91%) provided large-print labels/leaflets, 82% had wheelchair access, and 64%provided dementia-friendly space. However, only about a third had automatic door assistance, hearing loop or bell at the front door.

In about half of pharmacies Gujarati and/or Punjabi were spoken, while in a third Gujarati. Polish was spoken in 14% of pharmacies. Most of pharmacies used a **language** service, such as Google Translate.

A third (34%) of pharmacies relied on locum pharmacists, relief pharmacist (32%) and 10% on other locum pharmacy staff. A similar proportion experienced **difficulties recruiting** community pharmacists, with about a quarter have difficulty recruiting pharmacy technicians, counter assistants or dispensers. One in five experience difficulty recruiting into apprenticeship in any pharmacy role, and 5% into delivery driver positions.

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Over third (36%) of pharmacies offered independent private prescribing and 14% independent NHS prescribing. A large proportion of pharmacies (81%) intended to change their **independent prescribing** practice, whether expanding or reducing.

A half of respondents said their pharmacy dispensed appliances.

A majority (91%) of pharmacies offered delivery services (free of charge in 95% of such pharmacies). Over a half (55%) of pharmacies noticed an increase in demand for online services and 68% for delivery services. Most practices looked into expanding their **online and/or delivery services**, with only 23% planning no such expansion. Many detailed comments on the possible impact of online ordering and online pharmacy indicated that a negative effect on community pharmacies is likely in the future.

7.2. PNA Pharmacy Public Survey

PRELIMINARY RESULTS – further analysis of LLR-wide results is ongoing.

This section the initial results of the PNA Public Survey which was run between 3rd of February to 30th of April 2025. The detailed report is available in the APPENDIX.

A total of **739 Leicestershire residents** responded to the survey, 74% (N=547) were Charnwood residents, 11% from North West Leicestershire (N=79), with other districts contributing to a much lesser degree. This raises questions about representativeness across Leicestershire districts. Over a half (53%) of respondents were 65 or above, 38% were 45-64 and 8% 25-44; the majority (63%) women; 95% declared themselves to be white, 4% Asian or Asian British.

Overall, 86% agreed, whether 'very' or 'fairly' that their pharmacy provided a **good service**, with 8% disagreeing. 85% agreed that advice received was clear, with 4% disagreeing.

The majority of respondents (90%) were getting their medication directly from a pharmacy, with 4% using GP dispensaries and 4% delivery. The majority of Leicestershire respondents (98%) were usually using Leicestershire pharmacies, with only 2% usually using pharmacies located in Leicester.

Almost a half (48%) of respondents used a car as a **means of transport** (including 41% as drivers); and 46% were walking. Only 1% of respondents were using public transport to get to the pharmacy; remaining 3% had their medicines usually delivered home. In the majority of cases (98%) the travel involved less than 30 minutes, including 80% less than 15 minutes. Only 1% of respondents travelled for more than 30 minutes to get to a pharmacy. The majority of those who have their medicines delivered, this is by necessity (e.g. disability) rather than choice/convenience.

Where applicable, the rates of satisfaction with **advice about taking medicines** (percentage of

those reporting being very/fairly satisfied) were as follows – 81% for pharmacies, 90% for GP dispensing and 64% for online pharmacies. Conversely, 7% were dissatisfied (very/fairly) with pharmacies, 4% with GP dispensing and 15% with online pharmacies.

The majority (89%) of respondents use pharmacies on the weekdays (9am-6pm), 6% on Saturdays and 4% on weekdays evening. Overall, 80% agreed (strongly/tend to) that **opening hours** met their need, with 2% stating that their needs were not met. The majority of respondents (98%) reported that it was easy (very/fairly) for them to find a pharmacy. None of respondents found it very difficult. It was easiest to find a pharmacy during a weekday (98%), relatively easy (55%) at weekend, but difficult (58%) after 6 pm on a weekday and on Bank Holidays (72% found it very or fairly difficult).

In the future, the majority of respondents (97%) plan to visit a pharmacy in person and 90% stated that they are not likely to ask for a prescription by post. Furthermore, 80% stated they are not likely to use online services and 76% perceived home delivery services as not important.

For the majority (92%) the availability of medication at a pharmacy was very important, as were quality of service (90%) and availability of private areas (83%). Only 1% thought that availability of information in other languages was important.

With regards to **additional services** provided by pharmacies, 84% of respondents were aware that pharmacies provide minor ailment advice, 70% of disposal of unused medicines service, 69% flu vaccinations and 68% BP checks, for example, however only 12% were aware of weight management, 13% physical exercise and 16% of healthy eating advice.

In summary, there is a good level of satisfaction with the services provided by local pharmacies, with respondents preferring to use local (Leicestershire) 'brick-and-mortar' pharmacies in person and not planning use online/distance options in the near future. The most important aspect seems to be the quality of the service and the availability of the medication. Pharmacies are harder to find after hours on weekday and on Bank Holidays. While residents are aware of additional clinical services provided by pharmacies, they are less aware of public health, and lifestyle advice.

8. Responses to Statutory Consultation

TBC after consultation in June-July 2025.

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9. Digital Developments

PharmOutcomes[26] is a web-based platform used by community pharmacies to record and manage patient services. It helps track service effectiveness, streamline management, and facilitates analysis for both local and national level reporting[27]. It allows pharmacies to document and manage various services like flu vaccinations, consultations, and hospital discharge referrals. It has a role in service design and customisation, audit and management, EMOP (Electronic Medicines Optimisation Pathway) support, invoicing, data analysis and report, as well as evidence gathering on community pharmacy services.

Since 2016, community pharmacies are able to access an electronic **Summary Care Record (SCR)**[28] for patients. SCR is a national database that holds electronic records of important patient information such as current medication, allergies and details of any previous bad reactions to medicines, created from GP medical records. It can be seen and used by authorised staff involved in the patient's direct care, such as accident and emergency services, 111, ambulance, community care, GPs, hospital services, primary care, substance misuse, maternity and other direct care providers. Its aim is to make care safer, reduce the risk of prescribing errors and help to avoid delays to urgent care.

The **Electronic Prescription Service (EPS)**[29] allows prescribers to send prescriptions electronically to a dispenser, such as a pharmacy, nominated by the patient. This makes the prescribing and dispensing process more efficient and convenient for patients and healthcare workers. EPS is already widely used in primary care with over 95% of all prescriptions now being produced electronically. It is widely used in primary care, but its capability has been expanded to secondary and community care, including acute, community hospital trusts, and mental health trust.

Digital Leicestershire[30] is a programme led by Leicestershire County Council, is improving Leicestershire's digital connectivity and ensure easier access to public services, particularly in rural locations. Under the Government's £5bn Project Gigabit aimed at delivering gigabit-capable broadband to hard-to-reach communities, Leicestershire initiative was the first in the country to be rolled out. By March 2024, it connected 43 public sector sites (schools, libraries, waste sites and depots) with gigabit-capable broadband, improving digital inclusion across the County.

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10. Gaps in Current Provision

This section discusses potential gaps in current provision of pharmaceutical services in Leicestershire identified in this review of the PNA.

Gaps can be looked at from a number of perspectives[31] - geographically (whether residents have sufficient access to a pharmacy driving, walking or by public transport – location and spread of premises), whether there are geographical gaps in provision of specific services and whether there are accessibility issues with resulting from gaps in pharmacy opening times.

10.1. Location of Premises

The geographical analysis of travel time to pharmacies in Leicestershire indicate just two areas in the East of Harborough and Melton districts where travel time to a Leicestershire or borderline pharmacy is over 20 minutes (Figure 15, page 48), however, these areas are within a relatively short drive from Oakham and Uppingham with a number of pharmacies there. Furthermore, these areas are very sparsely populated – only in Harborough there is a small proportion of population with more than 15 min drive to a pharmacy (Figure 14, page 47).

In conclusion, there is very good access to community pharmacies across all Leicestershire Districts.

10.2. Opening Times

During weekdays there is a good coverage of services with eight out of ten pharmacies open till 6 pm or later and over a quarter (28%) open before 9 am. The access is more restricted at weekends, particularly on Sunday night (only two pharmacies open, one in Blaby and one in Hinckley and Bosworth).

10.3. Equality of Access

The analysis of equality of access to pharmaceutical services in Leicestershire has found no disparities by age or deprivation, however, those living in the rural settings have much longer travel times, particularly when using public transport or walking to a pharmacy.

10.4. Services

10.4.1. Essential Services

Combining all three providers of essential pharmaceutical services (community pharmacies, distance selling pharmacies and dispensing GPs), the residents of Leicestershire have similar

levels of access (2.0 providers per 10,000 population) to the England average of 2.1 of community pharmacies per 10,000 population (par 6.3.2, page 43). Both dispensing GPs and distance selling pharmacies are important providers of essential services for rural population of Leicestershire.

Whilst current access to pharmacy provision is largely good, with the projected **increases in population** that are anticipated in Leicestershire, the areas of Harborough, Hinckley and Bosworth, and North-West Leicestershire should in particular be kept under review to ensure that the provision remains adequate to meet the future needs of the populations in these areas. The large amount of housing development in the county should also be kept under review and taken into consideration as this may present particular geographical areas of need for further pharmaceutical services.

Although no gaps have been identified in the provision of essential services during normal working hours or outside of normal working areas across the whole Health and Wellbeing Board area and no gaps have been identified in essential services that if provided either now or in the future would secure improvements or better access, housing and population growth need to be kept under review with a focus on Harborough, Hinckley and Bosworth and North West Leicestershire.

10.4.2. Advanced and Enhanced Services

The analysis shows no significant gaps in the provision of advanced or enhanced services in Leicestershire, with a majority of community pharmacies signed up to provide these service. An exception is Smoking Cessation Service (SCS) with about a third of pharmacies signed up (lowest - 11% in Melton).

10.4.3. Locally Commissioned Services

The analysis shows no significant gaps in the provision of locally commissioned services in Leicestershire. From October 2025 EHC (Emergency Hormonal Contraception) will be commissioned nationally together with the Advanced Pharmacy Contraception Service.

Two services where access by Leicestershire residents could be an issue are - H. Pylori Breath Test Service which is only available in Leicester (for Leicester residents) and the Urgent Supply and Home Delivery Service for palliative care which is currently provided by only one pharmacy (based in Leicester) across the whole of LLR.

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11. Recommendations

THIS SECTION IS CURRENTLY IN DRAFT - TO BE DEVELOPED FURTHER ON COMPLETION OF THE STATUTORY CONSULTATION (AUGUST 2025)

To ensure **equity of pharmaceutical services provision** for Leicestershire residents it is recommended that ICB/NHSE/LCC (as appropriate) periodically update the Leicestershire Health and Wellbeing Board on the following:

- Current **locations and opening times of community pharmacies**, in light of population and housing growth, including emerging housing developments and changes in local housing policy
- Equity of the coverage and uptake of **advanced** and **locally commissioned services**, such as Pharmacy First, contraception and hypertension case-finding services, considering cross-border provision, particularly in Leicester and Rutland, but also other bordering authorities
- Any changes in the availability of public, community and voluntary **transport provision** to pharmacy and GP dispensing locations
- Any **recruitment difficulties** for pharmacies, use of private consultation rooms and timely access to some medicines.

Action is also recommended to increase use of pharmacy services in **promoting health and healthcare management**. ICB/NHSE/LCC (as appropriate) should periodically update the Leicestershire Health and Wellbeing Board on the following:

- Progress with any relevant local **campaigns**, particularly jointly defined and/or run by NHSE, ICB and LA Public Health.
- Any **strategic developments** ensuring increasing role of pharmacies in preventing ill-health, supporting wellbeing of the population and providing clinical care for patients.
- Progress in **integrating pharmacy services into the primary care offer** locally and ensuring strategic engagement of pharmacy staff.

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12. Conclusions

THIS SECTION IS CURRENTLY IN DRAFT - TO BE DEVELOPED FURTHER ON COMPLETION OF THE STATUTORY CONSULTATION (AUGUST 2025)

The LLR Reference Group agreed on the following conclusions of this PNA, providing continuous level of funding reflecting future population changes.

Currently, there is a good provision of a variety of pharmaceutical services across the county of Leicestershire to meet the health needs of the population. The services are distributed across the localities, with good levels of access by residents to pharmacies in Leicestershire or, where available, across the County border.

However, the projected population increases and housing growth in Leicestershire may lead to a reduction in services and it is vital that access is monitored to assure expected level of provision throughout the three-year life cycle of this PNA.

The key role of community pharmacies in future healthcare, particularly their contribution to the integrated local primary care offer, will require effective neighbourhood working arrangements. This is directed by both national and local priorities (see Section 5, page 36).

12.1. Statements of the PNA

THIS SECTION IS CURRENTLY IN DRAFT - TO BE DEVELOPED FURTHER ON COMPLETION OF THE STATUTORY CONSULTATION (AUGUST 2025)

The PNA is required to state what is considered to constitute Necessary Services as required by paragraphs 1 and 3 of Schedule 1 to the Pharmaceutical Regulations 2013.

The regulations require the following statements[31]:

1. the pharmaceutical services that the health and wellbeing board has identified as services that are necessary to meet the need for pharmaceutical services
2. the pharmaceutical services that have been identified as services that are not provided but which the health and wellbeing board is satisfied need to be provided in order to meet a current or future need for a range of pharmaceutical services or a specific pharmaceutical service – *i.e. gaps in the provision of necessary services*
3. the pharmaceutical services that the health and wellbeing board has identified as not being necessary to meet the need for pharmaceutical services but have secured improvements or better access – *i.e. other, already existing, relevant services, advanced, enhanced or locally commissioned*
4. the pharmaceutical services that have been identified as services that would secure improvements or better access to a range of pharmaceutical services or a specific

pharmaceutical service, either now or in the future *i.e. other, potential services, that would secure improvements in access*

5. other NHS services that affect the need for pharmaceutical services or a specific pharmaceutical service

For the purposes of this PNA, pharmaceutical services are classified into Essential, Advanced, Enhanced and Locally Commissioned (LCS) Services, in line with the CPCS classification used by the local services and commissioners.

12.1.1. Provision of Essential Services

There is a sufficient provision of essential pharmaceutical services for the population of Leicestershire.

12.1.2. Gaps in Provision of Essential Services

No gaps were identified in the provision of Essential Services during normal working hours or outside working hours across Leicestershire to meet the needs of the population currently or in the next three years (lifetime of this PNA) across Leicestershire.

Recommendation – review housing developments.

12.1.3. Other Services

Advanced Services

According to the information available, there are no gaps in the provision of Advanced Services at present or within the next three years that would secure improvements or better access to services in Leicestershire.

Enhanced Services

According to the information available, there are no gaps in the provision of Enhanced Services at present or within the next three years that would secure improvements or better access to services in Leicestershire.

Locally Commissioned Services

According to the information available, there are no gaps in the provision of Locally Commissioned Services at present or within the next three years that would secure improvements or better access to services in Leicestershire.

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12.1.4. Gaps in Other Services

Currently, no suggestions for further access locally, but this statement will depend on results of local engagement (surveys and consultation).

12.1.5. Other NHS Services

This statement will depend on results of local engagement (consultation).

12.2. Future of Pharmacy Services in Leicestershire

In September 2023, Nuffield Trust and King's Fund published a research report outlining a future of community pharmacy[32]. The main themes include:

1. **Preventing ill health and supporting wellbeing**, through supporting people and communities to stay healthy and well, with a particular focus on reducing health inequalities. Specifically, through public health interventions such as smoking cessation advice, weight management and alcohol advice, targeted health checks and screening offering joined-up women's health services, evidence-based advice on vitamin supplements, supporting local vaccination offers, and delivering vaccinations, signposting and/or referring people on to other support and playing an increasing role in providing opportunities for early detection.
2. **Providing clinical care for patients**. Expanding on Pharmacy First concept, diagnosing and managing a wide range of acute common ailments, prescribing medications to treat these when clinically appropriate, supporting the identification and management of some common long-term conditions such as asthma and diabetes, disease monitoring and optimising the use of medicines and devices, case-finding, initial prescription and titration for hypertension, plus ongoing management of hypertension.
3. **Living well with medicines.** Supporting people to access and to live well with their medicines and treatments, including new and advanced therapies whenever they emerge. Community pharmacists will be playing an increasing role in medicines optimisation services, wider use of pharmacogenetics and greater personalisation of medications, particularly around management of long-term conditions, as well as providing in-reach services to settings such as care homes to support providers in optimising medicines management.
4. Community pharmacy teams will be an **integral part of a local integrated primary care offer**, allowing people access to care in their own neighbourhoods and supporting people with ongoing care needs in addition to preventive and acute care through taking a co-ordinated and active role in the work of PCNs, agreeing principles and protocols for

data sharing between different providers in the neighbourhood, or better aligning contracts to ensure that collaboration is incentivised and supported.

The increasing role of community pharmacy in the integrated primary care was recognised in the recent **CPCF settlement for 2024/25 and 2025/26** described in more detail in **Section 6.9**, page 82.

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Glossary of Terms

AUR	Appliance Use Review
CBS	Community Based Services
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CPCF	Community Pharmacy Contractual Framework
CPCS	Community Pharmacist Consultation Service
DHU	Derbyshire Health United
EHC	Emergency Hormonal Contraception
EPS	Electronic Prescription Service
GP	General Practitioner
HWB	Health and Wellbeing Board
IMD	Index of Multiple Deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LCC	Leicestershire County Council
LCS	Locally Commissioned Services
LLR	Leicester, Leicestershire and Rutland
LPS	Local Pharmaceutical Services
LSOA	Lower Super Output Area
MSOA	Middle Super Output Area
MUR	Medicines Use Review
NHS	National Health Service
NIAVS	National Influenza Adult Vaccination Service
NMS	New Medicines Service
OHID	Office for Health improvement and Disparities

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ONS	Office for National Statistics
OOH	Out of Hours
PGD	Patient Group Direction
PHOF	Public Health Outcomes Framework
PNA	Pharmaceutical Needs Assessment
POPPI	Projecting Older People Population Information System
QOF	Quality Outcomes Framework
SCR	Summary Care Record
SCS	Smoking Cessation Service
UPA	Ulipristal acetate
UTI	Urinary Tract Infection

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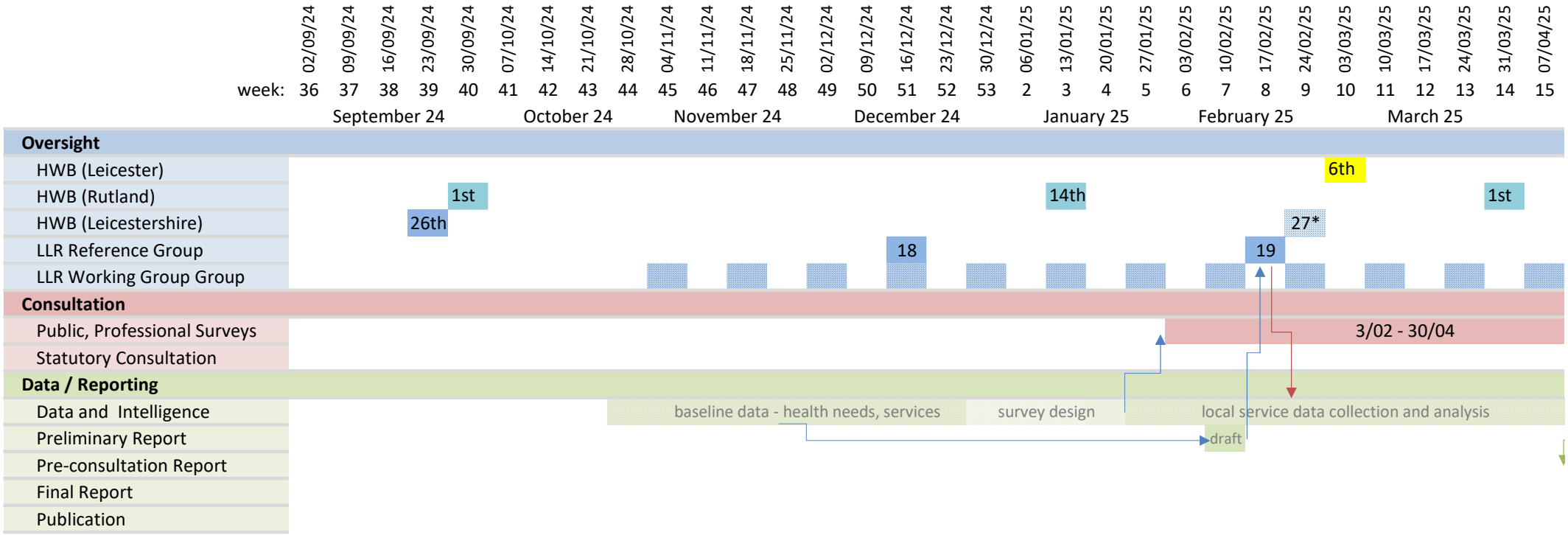
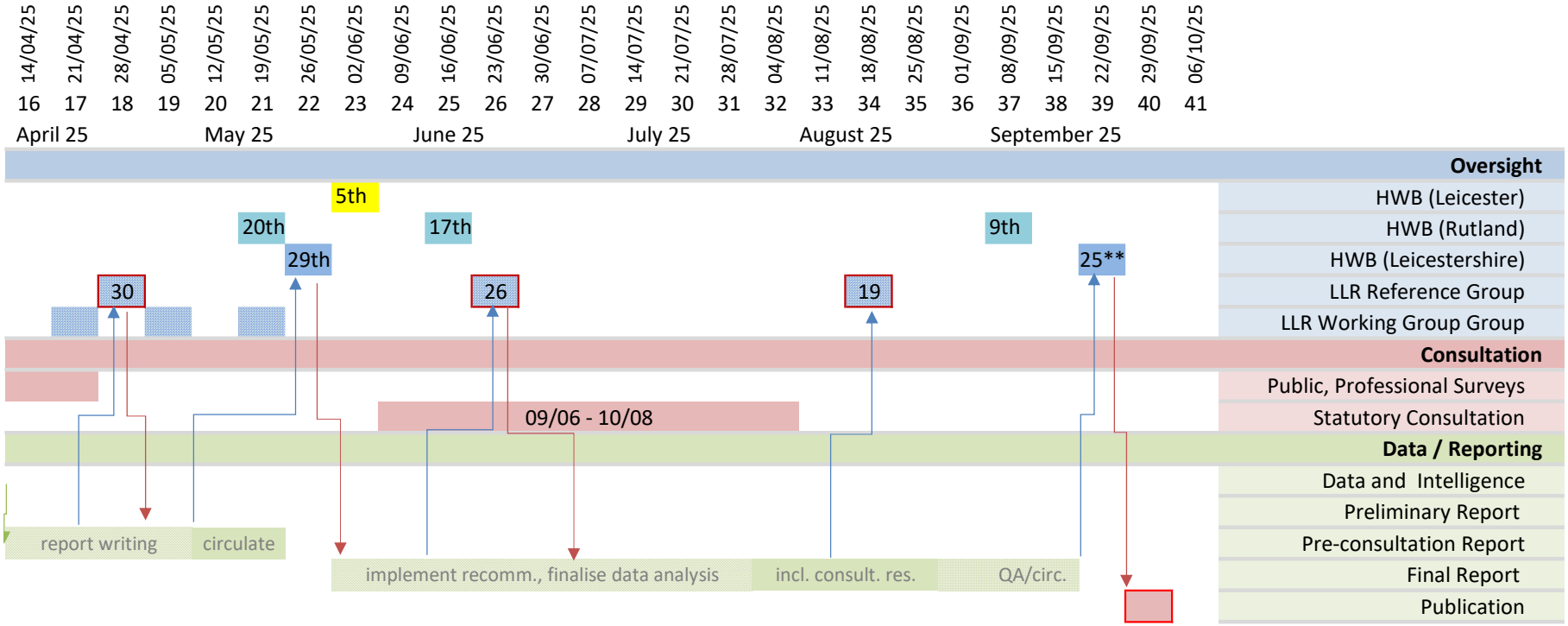
APPENDIX B - 2025 PNA Project Timeline



LLR Reference Group dates:

		Focus:
18/12/2024	**1**	First meeting - initial process, scope, ToR etc
19/02/2025	**2**	Update on the analysis (preliminary reports or a presentaion), data gaps and consultation
30/04/2025	**3**	Update including local and professional survey results
26/06/2025	**4**	Report progress, any additional analyses of data (national and local)
19/08/2025	**5**	Update on statutory consultation, sign off the final report draft fot the HWBs

APPENDIX 3 - 2025 PNA Project Timeline



Agenda Item 10

Leicestershire County Council

HEALTH AND WELLBEING BOARD 29 MAY 2025

REPORT OF LEICESTERSHIRE COUNTY COUNCIL

REFRESH OF ADULTS AND COMMUNITIES STRATEGY 2025-29 DELIVERING WELLBEING AND OPPORTUNITY IN LEICESTERSHIRE

Purpose of report

1. This report is to provide information relating to the refresh of the Adults and Communities Strategy, titled Delivering Wellbeing and Opportunity in Leicestershire 2025-2029, attached as an Appendix to this report.

2. This is a *watch item* for the Health and Wellbeing Board. The strategy details aims for the Adults and Communities Department to prevent need, reduce need, delay need and meet need for the people of Leicestershire. It also has aims to reduce health inequalities particularly for people with a Learning Disability.

Recommendation

3. The Board are invited to comment on the Adults and Communities Strategy 2025-2029, as part of the consultation process.

4. The Board are requested to comment on how the Adults and Communities Department can continue to work in collaboration with the Board to support the wellbeing needs of the people of Leicestershire.

5. The Board are asked to note the aims outlined within the strategy. These will form part of the Adults and Communities Department's business plans over the next four years and will highlight areas of opportunity for collaboration, if these also sit within the Board's focus.

Policy Framework and Previous Decision

6. This is a new item being presented the Board. It does follow a previous Adults and Communities strategy 2020-2024 which was agreed at Cabinet on 18th December 2020.

7. The draft strategy aims to support Leicestershire County Council to meet its statutory duties including those cited in the Care Act 2014; the Mental Health Act 1983; Mental Capacity Act 2005; Public Libraries and Museums Act 1964.

8. The draft strategy also supports the Adults and Communities Department to deliver the requirements of the following:

- The Care Quality Commission's (CQC) assessment of the Adults and Communities Department's adult social care service;
- Arts Council England and The National Archives Accreditation Schemes;
- The Visitor Attraction Quality Assurance Scheme;
- Ofsted's assessment of Leicestershire's Adult Learning Service.

Background

9. The draft Strategy follows on from the Delivering Wellbeing and Opportunities: Adults and Communities Department Ambitions and Strategy for 2020–2024 and provides a framework for policy, process and ways of working for the Adults and Communities Department.

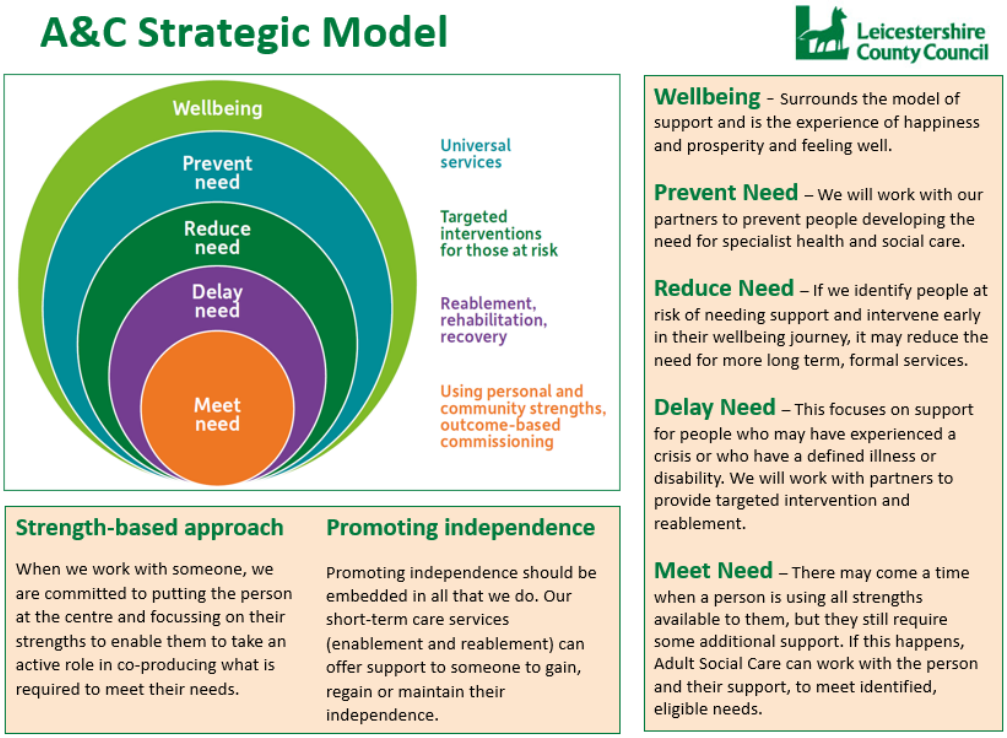
10. All services operate within the County Council's frameworks and corporate strategies such as the County Council's Strategic Plan 2022–2026, the People Strategy 2024–2028, and the Equality, Diversity and Inclusion Strategy.

11. The draft strategy details the Adults and Communities Department's aims over the next four years to meet our strategic and statutory requirements. The Department is made up of the following service areas:

    - Adult Social Care;
    - Culture Leicestershire (libraries, museums, heritage sites, cultural participation and collections and learning);
    - Adult Learning.

12. The strategy continues the strategic approach of the existing strategy, focussing on the model of Wellbeing, Prevent, Delay, Reduce and Meet need and provides the aims for the different services across the Department over 2025–2029.

13. Whilst continuing with the strategic model mention above (also see diagram below) the new strategy highlights the commitment to strength-based approaches whilst promoting independence. In addition, aims have been set along with actions for communication, engagement and supporting delivery alongside aims and actions for people (internal and external workforce, carers and equalities, diversity and inclusion [EDI]).



14. There are ambitions embedded within the current strategy which are still valid for this refreshed version. These themes are to continue with new, updated descriptors about how the ambitions will be realised. The ambitions include:

- Improved customer experience and satisfaction
- Promoting wellbeing through universal services
- Developing and supporting inward investment for new social care accommodation
- Promoting independence
- Working effectively with partners including co-production, co-design and engagement
- Providing high quality information and advice
- Seamless transition from children to adult services
- Building a flexible, talented, motivated workforce including apprentices
- Improved use of technology

15. The draft Strategy has been created through engagement and co-production with people who draw on the different service areas in Adults and Communities, officers and managers and care providers.

16. To date, the draft strategy has been created, public consultation has concluded and the review of the consultation comments are underway.

17. Next steps are to report the outcome of the consultation to the Adults and Communities Overview and Scrutiny Committee and Cabinet in June, make any necessary changes, and launch the new strategy in late June/early July.

18. The aims and actions from the strategy will inform business planning for the Adults and Communities Department for 2025-2029.

Proposals/Options

19. Whilst the request of the Board is one of watching and awareness, the strategy recognises the Department's key relationships with partners in delivering wellbeing and opportunity to the people of Leicestershire.

20. The Department propose that the Board reviews the aims and actions that have been identified and consider how the Department can collaborate with the Board to achieve shared aims and actions.

Consultation/Patient and Public Involvement

21. The public consultation commenced on the 18th February 2025 and ended on 14 April 2025.

22. The consultation involved an online survey, which could be printed and posted upon request. There was an adapted (Easy Read) version of the survey and the draft strategy available.

23. The responses from the consultation have been positive, with over 80% of respondents scoring Strongly agree or Tend to agree for all questions relating to the strategy's aims or aims/actions from our strategic model (wellbeing, prevent need, reduce need, delay need and meet need).

24. The outcome of the consultation will be presented to the Adults and Communities Overview and Scrutiny Committee on the 2 June 2025 and the final review of the consultation outcomes and recommended amendments (if any) to the strategy will be presented to Leicestershire's County Council Cabinet on 17 June 2025

Resource Implications

25. The Adults and Communities Department will meet any resource implications to finalise the strategy.

26. Funding for services or aims and actions relating to the strategy will be met with current business as usual funding. This will be subject to change depending on Medium Term Financial Strategy requirements and any other funding impacts that could occur between 2025-2029.

Background papers

Delivering Wellbeing and opportunity in Leicestershire – Adults and Communities Department Ambitions and Strategy for 2020-24

Leicestershire County Council Strategic Plan 2022-26

Leicestershire County Council People Strategy 2024-2028

Equality, Diversion and Inclusion Strategy-2024-2028

Cabinet Agenda 18th December 2020 (previous strategy)

Circulation under the Local Issues Alert Procedure

27. None.

Officer(s) to Contact

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Appendix

Draft Adults and Communities Strategy 2025-2029 – Delivering wellbeing and opportunity in Leicestershire

RELEVANT IMPACT ASSESSMENTS

Equality Implications

28. The strategy focuses on services provided by the Adults and Communities Department. These include statutory services with specific eligibility criteria set out in legislation.

29. The draft strategy has been subject to an Equalities Impact Assessment (EIA) and a Health Impact Assessment. Both have been subject to review and scrutiny by the relevant oversight processes.

30. The EIA highlights mainly positive impacts upon people with protected characteristics. These are as follows:

- It refers to the County Council's People Strategy and its commitment to ensuring EDI remain a strong focus over the new Strategy period.
- Within the service offer of Culture Leicestershire and Adult Learning, it refers to bringing communities together; providing learning to overcome barriers; offering courses in a range of formats and venues to the suit learning needs of people.
- Culture Leicestershire also has an aim within the Strategy to reach more diverse communities across the County.
- The Strategy references the aim to tackle digital exclusion so that if information is provided on the internet, via email, or another electronic means, people who would struggle to access information in this way will have the opportunity to have the means and skills to do so.
- The Department and Strategy will also support vulnerable people and people living with disabilities within their communities.

31. Whilst the strategy EIA highlights mainly positive impacts, the following are mitigations that apply to it.

- There is an aim within the strategy to work with partners to provide people with the skills needed to tackle digital exclusion
- There will be an easy read version of the strategy for people to access if they have certain disabilities or for those who find it difficult to read the Strategy document in its current format.
- The Department will monitor the data of our population, demographic data around the people who access our services and feedback received to ensure our services are accessible and inclusive and offer good outcomes for all.

Health Implications

32. The new strategy aims to have a positive impact on seven of the identified 12 Health Impact domains. The remaining five have been assessed as neutral.

Human Rights Implications

33. The revised Strategy aims to have a positive impact on a person's Human Rights through delivery of statutory provision, meeting legislative duties, a focus on rights-based practice and the promotion of family life and independent living

Partnership Working and associated issues

34. The strategy references partnership working with agencies such as the Police, the Integrated Care Board and the charity and voluntary sector.

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Leicestershire County Council

APPENDIX

Adults and Communities Strategy 2025-2029

Delivering wellbeing and opportunity in Leicestershire








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Foreword

We are delighted to present Leicestershire County Council's Adult and Communities strategy. We are ambitious in our vision to deliver wellbeing and opportunity in Leicestershire and ensure that all adults living in Leicestershire, lead active, independent, and fulfilling lives.

Jon Wilson
Director of Adults and Communities

Our focus on wellbeing and prevention is reflected in how we plan and deliver flexible and responsive adult social care and community wellbeing services. We endeavour to deliver person-centred and strength-based care, and have a strong commitment to equalities, diversity, and inclusion, striving to improve outcomes for people who are likely to experience inequalities.

Partnership-working is integral to the delivery of our priorities and as such we collaborate with partner agencies, including to jointly-commission services where this improves outcomes for people. We regularly communicate with and support providers to identify and mitigate any risks, assure the sufficiency of the care market, and continuously improve the quality of care.

Co-production is imperative to ensuring that our services reflect and address the views and experiences of our residents, and we are keen to embed it as an integral part of our service design and delivery.

Feedback from people who receive our services tells us what we are doing well, and where, and how services could improve. We will continue to adopt new ways to engage with people in our communities and those who draw on our services.

We want people to be able to live their best lives and will support people through participation in their communities; through spiritual and cultural activities; through learning and skill development; and through the provision of services to gain, regain and maintain people's independence.

Key to this ambition is to ensure we deliver the right services, in the right place, at the right time, and to ensure we deliver the best value to local people through cost effective support and continuous improvement.

As leaders, we continue to champion our culture, heritage, learning and adult social care services to ensure that services support the best outcomes for people in Leicestershire.

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Contents

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Introduction

This Leicestershire County Council Adults and Communities strategy details the ambitions, aims and goals of the department over the next four years (2025 – 2029).

The Adults and Communities department covers a wide range of service areas who work collectively to deliver wellbeing and opportunity to the people of Leicestershire. These are:

Culture Leicestershire

This covers Leicestershire's Libraries; Museums and Heritage; Collections and Learning and Cultural Participation services.

These are delivered across the county from over 50 venues, community spaces and people's homes or care settings. Where services are provided, the commitment is to be as cost and energy efficient as possible, using renewable energy sources and supporting biodiversity.

Services are delivered by a paid workforce and a range of volunteers that enhance and extend the offer. Together they provide services that contribute significantly to improving people's health and wellbeing, whilst supporting community cohesion and building resilience.

Culture Leicestershire aims to create space to spark imagination, celebrate communities and enhance wellbeing. They also work to the Investment Principles set by Arts Council England: Dynamism, Ambition & Quality; Environmental Responsibility; Inclusivity & Relevance.

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Adult Learning Service

The Adult Learning Service uses education to improve life chances.

Our adult learning courses are not only designed to improve adults' educational attainment, they also support the development of skills required for work and career progression and the skills and knowledge required to support self-care and resilience. The service contributes to the local economy through income generated when providing its courses and from recent learners who have gone on to secure paid employment.

Working alongside our regional partners, including voluntary organisations and further education colleges, the service offers learning around the following key themes:

- Equipping parents/carers to support children's learning
- English and English for Speakers of Other languages (ESOL)
- Mathematics
- Digital
- Engagement and/or building confidence
- Preparation for employment
- Career progression
- Preparing for further learning
- Promoting health and wellbeing
- Improving essential skills
- Developing stronger communities

Our Adult Learning Service is guided by the Ofsted Education Inspection Framework. All their programmes are learner centred and can be tailored to individual needs.

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Adult Social Care

Promotes, supports and maintains wellbeing and the independence of people in Leicestershire.

Our **Adult Social Care vision** has been adapted from the Social Care Future vision:

> **Adult Social Care wants every person in Leicestershire to live in the place they call home, with the people and things that they love, in communities where they look out for one another, doing the things that matter to them.**

To achieve this, the department will provide:

Quality information provision – providing access to guidance, advice and support to enable people to live well and make best use of their local resources.

Assessments and support – assessing need, working together with the person, their family, friends and networks to build the best support possible.

Independent living – this could be through adaptations, short-term care, care technology equipment or paid and non-paid support.

Supported accommodation – this could be a Care Home, Supported Living or Extra-Care and Shared Lives providing an environment suitable to meet someone's ongoing care and support needs.

Support to carers – assessing the needs of those in a caring role and providing information, guidance and support.

Protection to adults at risk – through our functions of Safeguarding; Deprivation of Liberty Safeguards (DoLS); Advocacy and Voluntary services; Mental Capacity Act and Mental Health Act duties, we will work to keep people safe and well. We will improve practice and outcomes by seeking feedback from people who have received our services or received safeguarding interventions.

Commissioning and quality – ensuring Adult Social Care services are safe and meet the needs of the public.

Adult social care finance – provide a consistent framework for everyone receiving adult care services

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Our Values

As a Local Authority, we have adopted the following core values and are committed to delivering these in all that we do.

Positivity

We find the best way to get things done, and aspire to be the best we can. We deliver quality services and inspire others to deliver results.

Flexibility

We adapt to support the needs of the business. We work creatively, collaboratively and support our colleagues.

Trust and respect

We take ownership and accountability for our actions. We value diversity. We're inclusive and listen to the views of others.

Openness and transparency

We are honest with the people we work with and serve. We share information and communicate clearly.

Delivering the aims and outcomes of this strategy will also support the delivery of Leicestershire County Council's Strategic Plan.

How we have come to the outcomes in this strategy

This strategy has been developed

- through the process of co-production and engagement with the public we serve, our providers of services, the people we work with and our partners
- by reviewing the progress made in our previous strategy and using local data and our statutory requirements
- with learning from the challenges of the last strategy period and recognising some may be on-going. We aim for this strategy to be responsive to the current and future challenges whilst driving progress and success
- following the review of Leicestershire's demographic data. The population of Leicestershire aged 18 or over is expected to reach 621,352 by 2029, an increase of 5.5% from the mid-year estimate in 2023. This includes a 13% increase of people aged 65 or over - an additional 20,130 people compared with 2023. Furthermore, the population aged 85 or over is also expected to grow by 15.8% by 2029 and by 44.7% by 2033 (an extra 8,900 people in this age-group).

With the increases in population and the expected impact this will have on service demand, we will ensure we use all available resources to meet the outcomes of our communities and this strategy, whilst ensuring services are good value for money.

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Mission statement

As a department and with people who use our services, we concluded that the following statement still identifies what our department is striving to achieve:

Adults and Communities - Delivering wellbeing and opportunity in Leicestershire

Ambitions

Our overall ambition is to promote the wellbeing and independence of the people of Leicestershire. This may be through our universal service offer which includes our libraries, museums and cultural participation, or through our Adult Learning Service and Adult Social Care services.

Partnership working is the key to success in promoting wellbeing and independence within Leicestershire. We will work with people, their support networks and local communities, alongside our partners, including Public Health, NHS and local authority partners, adult social care providers and charity and voluntary organisations.

Through learning provided by our Adult Learning Service and information from our libraries, people can learn to overcome personal barriers to maintain their independence. Those with a sudden need for adult social care can be supported by our short-term care (reablement) teams.

The key to promoting independence is understanding what people need. Across the department, we will focus on co-production, co-design and engagement with the people of Leicestershire and our partners to design and deliver the most effective services to meet people's needs.

We will review and make improvements around our customer experience and satisfaction. When people feedback to us, whether this is through our annual adult social care surveys or through our comments, compliments and complaints procedures, we will address areas where we can make improvements.

As digital advancements become more accessible, we will make improvements to how people access information and interact with our services. This includes, where appropriate, the use of new and improved technology to meet a care need. We will also offer support around digital exclusion (where people are not able to use the internet or devices) so that we are still inclusive and accessible.

We will encourage developers and providers to build new accommodation in the county for people who draw on care and support.

As young adults with disabilities transition into adulthood, we will work with Children and Family Services through our Preparing for Adulthood pathway. For those who will transition with our YAD service, we aim to develop independence where appropriate.

To achieve the outcomes of this strategy, we will continue to develop our flexible, talented and motivated workforce. This includes offering apprenticeships to develop the skills and knowledge required to succeed in our services, whilst providing our team members with a valued qualification.

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Strength-based approach

Promoting independence, using a person's strengths or assets, or being strength-based will be referred to throughout the aims of this strategy.

The Social Care Institute for Excellence (SCIE) details a strength-based approach to be "a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets."

A person's strengths can come from themselves, their families and friends, professionals involved in their care and their local communities. When we work with someone, we are committed to putting the person at the centre and focussing on their strengths. This enables them to take an active role in co-producing what is required to meet their needs, with the people and communities they have around them and being as independent as possible.

This means we will understand what is important to a person and what they are able to do for themselves, identify who supports them or who could support them (for example a family member, a community group/ charity or a health led service) and promote independence by using their strengths.

Promoting independence

When working with our communities, promoting and maximising independence should be embedded in all that we do.

The potential for independence will be different from one person to another and will be dependent on their current situation. We have a range of short-term care services (enablement and reablement) which can offer support at the point of a crisis, or sudden change in circumstance, to enable someone to gain, regain or maintain their independence.

These currently include the Homecare Assessment and Reablement Team (HART) and our Community Reablement Workers.

Aims of our strategy

We will

- Build upon the HART service and the strong outcomes it achieves for people by working with our health partners to grow the service offer
- Refocus our mental health reablement teams to work with individuals, linking them into local communities and reducing the need for formal care services
- Develop new pathways for people of a working age, focussing on short-term interventions
- Create and commission new progression services for people with learning disabilities, autism and mental health challenges as part of their life journey towards maximising independence

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Our strategic approach

To deliver our aims and goals, we have developed a layered model that is designed to maximise a person's independence whilst promoting their wellbeing.

This strategic approach has four key areas which are surrounded by a person's wellbeing. These key areas are designed to offer the right support, at the right time and will vary in the amount of intervention needed by services to promote wellbeing and independence.

Universal services

Targeted interventions for those at risk

Reablement, rehabilitation, recovery

Using personal and community strengths, outcome-based commissioning

Wellbeing - this surrounds the model of support, services and opportunities that our Adults and Communities department provides.

Wellbeing is about 'how we are doing' as individuals and communities. Wellbeing is the experience of happiness and prosperity. It includes life satisfaction and a sense of meaning or purpose. More generally, wellbeing is just feeling well.

The Care Act 2014 sets out wellbeing in relation to a set of outcomes for people. Local Authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person.

As wellbeing will differ from one person to the next, Leicestershire County Council offers a wide range of services and opportunities to support wellbeing within our communities. These could be services from Culture Leicestershire, a course from our Adult Learning Service or services from Adult Social Care.

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Prevent need – We will work with our partners to prevent people developing the need for specialist health and social care services. We will provide information and advice which is accessible and co-produced. We will offer services that are accessible and open to all. These include libraries, museums and heritage services and adult learning services for people over 18 years of age.

Through working with local communities, volunteer groups and charities, we will respond better to what matters to our communities to keep people safe and well. We will continue to reach out to our seldom heard communities, ensuring that we provide information and services that are accessible to all.

Reduce need – If we identify people at risk of needing social care support in the future and intervene early in their wellbeing journey, it may reduce the need for more long-term, formal services.

This targeted intervention aims to keep people as independent as possible and reduce further needs developing. Our Occupational Therapy and Care Technology teams along with our adaptations offer may provide the level of support needed to maintain someone's independence without anything more. Attending an adult learning course may support to develop positive behaviours that help sustain good mental health.

Delay need – This focuses on support for people who may have experienced a crisis or who have a defined illness or disability. It may be support for someone following a life event such as a hospital admission or accident or when an illness or condition causes a deterioration in a person's ability to care for themselves.

To delay need, someone might access the Homecare Assessment and Reablement Team (HART) for targeted intervention or may be referred for short-term, goal setting support to recover from mental health challenges. Our services will work together with the individual, their families, support networks and our partners (such as the NHS) to ensure that people experience the best outcomes through the most cost-effective support.

Meet need – There may come a time when a person is using all of their available strengths but they still require some additional support. If this happens, Adult Social Care can work with the person and their support to meet identified, eligible needs.

If care and support services are required, these could be provided through the provision of a personal budget. This personal budget can be taken as a Direct Payment or can be managed by the council. The council will work with people to provide choice and control around how their care and support is met, seeking the best value for money, whilst maintaining a person's independence, health, safety and promoting wellbeing.

Setting clear progression outcomes with the person, whilst using their strengths and support, will mean people can become as independent as possible, as quickly as possible. This supports a person's wellbeing and allows Adult Social Care to ensure that any required support goes to the right person, at the right time.

To deliver our strength-based approach, we put the person at the centre of what we do and work with others involved in the care and support of the person. The following demonstrates this approach to doing what is 'right' for the person, to maximise their independence and wellbeing.

The right person: people who may need help or support are identified and prioritised

The right time: to prevent matters worsening for a person, increase resilience through a focus on strengths and maximise their independence

The right place: information, care and support provided at home, in the community or in a specialist setting, according to need and cost-effectiveness

The right support: to prevent, reduce or delay longer term need, without creating dependence, delivered by the right people with the right skills

The right partner: working more effectively with individuals, their friends and families and in partnership with other relevant organisations, to achieve more joined up or aligned and efficient support.

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"Setting clear progression outcomes with the person, whilst using their strengths and support...

...will mean people can become as independent as possible, as quickly as possible..."

We have listened to what our communities have told us and we will ensure that when we are working with a person, we will use words and language that supports them and their strengths.

At the right time to prevent escalation, increase resilience and maximise independence

At home or in the community where possible – according to need and cost effectiveness

Just enough of the right support to keep people safe and prevent, reduce or delay the need for more, without creating dependence: delivered by the right people

Engage and involve the person, their family and friends and in partnership with other relevant organisations to achieve joined up and cost-effective support

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How we will deliver this 2025 – 2029 strategy

People

What happens now

Leicestershire County Council is a values-led organisation and we are committed for this strategy to be delivered by a competent, skilled and supported workforce. This includes staff employed directly by the Council but also those who work in the wider social care workforce across Leicestershire. A competent, skilled workforce not only delivers quality and efficiency in what they do, it enables our valuable staff resource to be directed to where it is needed, at the right time.

In addition to our paid workforce, some of our Communities and Wellbeing services are delivered and supported by our skilled, volunteer workforce. Our volunteers support these services to run effectively and enable us to reach more people. During 2023 – 2024, volunteers provided 19,600 hours of their time to support our Culture Leicestershire services.

The care provided by Leicestershire's unpaid carers (families, friends, neighbours etc) to the cared for person also supports the wellbeing of our communities. During 2023 to 2024, the council supported 3,722 carers to maintain their caring role by commissioning services or providing information and advice, following a carers assessment.

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Aims of our strategy - we will

- Continue to offer our volunteers a volunteer manager and specialist training for their role
- Have a strong recruitment and retention programme, minimising the amount of people leaving their roles
- Invest in training and development, providing the opportunities, knowledge and skills people need to be highly skilled in their role
- Maximise the apprenticeship offer to develop future talent and leaders
- Ensure our commitment to Equality, Diversity and Inclusion (EDI) remains strong
- Strengthen the role of the Department Equalities Group in promoting equality actions for all
- Monitor staff wellbeing and through our wellbeing and support services, reduce absence and work-related impact on our teams
- Be adaptable to the recruitment needs of our care providers. This includes attracting a high-quality workforce, promoting opportunities for career development, piloting new cross sector initiatives and continuing to develop positive perceptions of adult social care careers
- Enable the adult social care sector to diversify in digital (where appropriate), complex care and mental health care to meet the needs of the county. This will be achieved by promoting specialised roles, providing courses to upskill and resources to support wellbeing
- Align our care providers recruitment strategies with the Skills for Care workforce strategy. This will unify a regional approach to support our external workforce recruitment
- Have reviewed the progress made against the current Leicester, Leicestershire and Rutland Carers' Strategy (2022-2025) and we will work closely with Leicestershire's carers and partners, to complete the follow up Carers' Strategy
- Support carers through stronger, early identification of their caring role. This will include improving how we signpost carers to what they need without them having to make contact with the Adult Social Care team
- Have completed our contingency planning project to support carers and their cared for person, should the carer not be able to fulfill their role

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Communication, engagement and supporting delivery

What happens now

We regularly meet with people in Leicestershire who support the department to shape what we do and how we do it. We have a well-established Engagement Panel and Learning Disability Partnership Board. With our people, we co-produce and engage on topics that will impact on those who may use our services.

We provide social care provider forums and updates, offering support and guidance on a regular basis, including training and quality improvement.

Aims of our strategy - we will

- Further develop the council's Engagement Panel to increase the diversity of its members, including connecting with groups who may not usually have contact with the council
- Deliver a commissioning programme to develop the adult social care provider market, aiming to increase choice and availability of quality services, provide new models of support and contracting, whilst delivering value for money
- Engage providers in developing services, allowing them to respond better to the commissioning needs of the county and department
- Support improvements in the quality of care of our provider market through training, quality support for adult social care providers, recruitment and retention service and positive behaviour support
- Make it easier for people to understand their care costs and what support is available to them
- Develop our self-serve financial assessment information, allowing the public to complete their own assessments, saving time and resources
- Enable people who receive adult social care support to plan for their financial future. By developing resources to help people plan early, they can identify who they may want to support them with their finances, if the time arises
- Provide the public with more accessible information about what the Adults and Communities department can offer

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"I am part of a collective voice with the other members of the Engagement Panel and together we try to make a positive difference for the people of Leicestershire. This gives me great satisfaction and purpose."

Martyn found out about the Adults and Communities Engagement Panel when receiving support from the Alzheimer's Society. Through the experiences Martyn had following his diagnosis and the impact this had on his life, he knew he wanted to make a difference to how statutory services are provided to the public.

Martyn found the Engagement Panel to be a friendly and open place, where all voices were heard. He soon settled into being a member and is currently the elected Chair.

The Engagement Panel has directly influenced many new service delivery changes, ranging from the development of new factsheets explaining Direct Payments, to commissioners seeking how unpaid carers could be better supported. The panel members offer their experience, oversight and comment to support changes that will impact on the people of Leicestershire.

Martyn feels it is vitally important for people who access services (now or may do so in the future) to be part of this process to ensure that the needs of the public are heard and being met, saying: "I am part of a collective voice with the other members of the Engagement Panel and together we try to make a positive difference for the people of Leicestershire. This gives me great satisfaction and purpose."

Martyn also says that the panel's voice is heard by senior leaders and a County Councillor, who attend the panel meetings.

Through his role in the panel, Martyn has visited other local authorities to share best practice and positive experiences.

Martyn is passionate about the next steps for the Engagement Panel and is keen to attract more members, from diverse backgrounds, whether these are cultural or linked to the condition a person is living with, so that the panel continues to have such a positive impact.

If you would like to be involved, please make contact A&C-Strategy@leics.gov.uk

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Wellbeing

What happens now

Our libraries, archive, museums, collections and learning resources are part of the glue that binds communities together and contributes to making them resilient and stronger. They allow people to develop, grow and feel connected to their local community. They can support people to realise their own potential and experience improved wellbeing.

Culture Leicestershire works with people of all ages, including children and families, to educate, build community cohesion and provide places, activities and resources to promote wellbeing. This could be supporting the development of literacy, language and social skills in early years children, to providing those aged 5 to 18 with access to a wide range of creative resources in school. Culture Leicestershire engages with individuals, families and communities to come together, celebrate, learn and have fun.

The Cultural Participation team co-create cultural activity and resources by supporting local people to shape how culture is interpreted, experienced and enjoyed. This community empowerment influences our heritage and library services and enhances wellbeing and community cohesion.

Culture Leicestershire also provides initiatives to support wellbeing through different activities and offers. These include the home library service; various projects which are community inspired and led; cultural services and volunteering opportunities.

Our Adult Learning Service supports wellbeing by providing our communities with the learning and skills needed to overcome barriers, gain employment and for self and family support. Through their programmes, learners will become empowered to take greater control of their lives and develop a greater appreciation about how they can influence things that have an impact on their own quality of life.

Being accessible is a fundamental principle for everything the Adult Learning Service provides. They understand the value of providing learning locally in the community and believe programmes should not be limited to large centres. To provide accessible programmes across the county, they aim to maintain a good range of courses in community venues such as libraries, schools and village halls. Where appropriate, online courses will be provided to support those that require additional flexibility to tailor learning around their busy lives.

The Adult Learning Service is also committed to removing barriers to success and will provide resources and support for learners with Special Educational Needs (SEN). A core element of the learning offer is a programme to support learners with learning difficulties and disabilities, supporting approximately 350 people per year.

The service offers bespoke courses around promoting independence, resilience and wellbeing. These include the knowledge, skills and behaviours associated with good health and wellbeing along with how to recover from poor mental health.

The Adult Learning Service also delivers a range of vocational programmes and in 2024, delivered training to over 80 apprentices, in a range of subject areas. Other workforce development programmes include the Care Certificate in collaboration with Adult Social Care, and British Sign Language and Digital Skills for the wider council workforce.

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The service provides Information, Advice and Guidance (IAG) to help adults find courses, volunteering and work experience opportunities.

Adult Social Care works with people and partners (such as the emergency services, adult social care providers, district councils and health and wellbeing services) to keep those most at risk, safe from harm and abuse. If someone has needs for care and support, and due to these needs is unable to protect themselves from harm and abuse (or the threat of harm or abuse) then Adult Social Care can support under its Safeguarding duties.

Adult Social Care also exercises its statutory responsibilities under other legislation, such as the Mental Capacity Act 2005 and the Mental Health Act 1983; 2007; 2022; to promote a person's legal rights and support their wellbeing.

Aims of our strategy - we will

- Continue to develop and deliver learning to meet the needs of the local economy, in co-production with people who may access the Adult Learning Service
- Raise the profile of our Adult Learning Service and adult education offer and show how they deliver wellbeing within our communities
- Provide resources, activities and opportunities through Culture Leicestershire, that enable communities and individuals to come together to share and celebrate culture, heritage and identity
- Develop future Culture Leicestershire services with the people of Leicestershire. A focus will be to engage with people who experience barriers in accessing these services
- Provide an archive space for our museum and collections services
- Promote 'Nothing About you Without You' within our Adult Social Care teams, ensuring that when we are working with a person, they are involved and at the heart throughout
- Develop our focus on 'rights-based' practice. This covers our Deprivation of Liberty Safeguards (DoLS), Mental Health Act Assessments, Safeguarding and our responsibilities to the Court of Protection
- Continue to learn from Safeguarding Adults Reviews and any other significant events that may occur. We will work with our partners to improve practice and implement change to keep those most in need, safe and well
- Creative Learning services to support pupils and teachers to develop cultural knowledge & skills through the provision of engaging learning opportunities

Russell is a 43 year old man with a learning disability. He is a very active person and is always keen to develop his skills to increase his independence.

Russell enjoys gardening and growing fruits and vegetables, keeping chickens and collecting their eggs and wanted to learn new skills in the kitchen to be able to cook a nutritious meal from scratch. This would support Russell to be more independent, leading to improved wellbeing.

Russell enrolled onto a (slow cooker) cooking course provided by the Adult Learning Service. The course was free and open to all learners. The providers of the learning contacted Russell before he was due to start to understand his learning needs and support was provided to enable him to fully participate.

During the learning, Russell prepared and cooked different dishes and learnt new skills to maximise his independence. At the end of the six weeks, all learners were presented with their own slow cooker to put their new skills into practice at home.

At home, Russell prepares and cooks meals using the slow cooker. He said the following about the course, "I liked meeting new people and all of it gave me a mental boost. I would have liked the course to have been longer... I really enjoyed it."

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Prevent need

What happens now

Our libraries offer a safe space and act as family hubs for communities. They have reached more people with the support of volunteers, different library formats and their digital offer. Libraries can reduce isolation and improve people's mental health and wellbeing.

With bespoke collections and initiatives, libraries promote self-help through their health and wellbeing collections. These cover health related themes, such as dementia and mental health and also learning opportunities for community growth, with their events programme on areas such as LGBTQ+ and Black History Month.

Within the museum sites in Bosworth, Donington-Le-Heath, Market Harborough, Melton Mowbray and Loughborough, collections are displayed that are reflective of the local communities being served or national events. These not only support tourism into the local areas but offer educational value on key elements such as preserving natural life and the impacts of climate change.

Our Adult Learning Service prevents the need for more formal services by offering courses designed to improve people's health and wellbeing whilst supporting what is needed to succeed in the employment market.

Adult Social Care works alongside partners, including Public Health, who provide different preventative and support services to improve the health and wellbeing of people in Leicestershire. Through access to their resources, such as Local Area Co-ordination, First Contact Plus and Community Timebank, people are supported to access their communities' strengths or universal support, to support their independence and promote their wellbeing.

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Aims of our strategy - we will

- Increase the number of people from disadvantaged neighbourhoods attending our adult learning courses
- Achieve higher graded outcomes of adult learners, whilst narrowing the gap in achievement across different learner groups
- Make our adult learning courses as accessible as possible through a developed, remote, online learning offer
- Develop Culture Leicestershire's portfolio of services to reach more diverse communities across the county
- Engage with our communities to co-create relevant cultural activities that celebrate communities, heritage and culture
- Coordinate community registers of local groups, charities, volunteer agencies, faith groups and others. People can reach out to their community before needing formal, paid services
- Develop our quality advice and information offer as technology becomes more accessible to more people
- Make contacting the right person within Adult Social Care (ASC) as quick and easy as possible. We know that people contact ASC for enquiries, information and guidance as well as seeking formal support. We will redesign this contact process to be quick and efficient, using a range of channels
- Better understand the benefits of Care Technology (where appropriate) to promote a person's independence
- Tackle digital exclusion with our partners (where a person cannot access some of our offer as they cannot use technology-based means)
- Continue to work with Local Areas Coordinators and Social Prescribers to support a person's wellbeing through an enhanced network in their local area

Culture Leicestershire's Creative Expression in Libraries (CEIL) programme offered children and young people at Birstall, Oadby, Shepshed and Melton Mowbray libraries a rich experience of working in partnership with highly-skilled creative practitioners.

In Birstall, pupils from Hallam Fields Primary School co-created a comic book project that inspired new ways to explore storytelling.

In Shepshed, pupils from Iveshead School created a BookTok video that encouraged other young people to pursue their own reading journeys. Separately, other young people within Shepshed engaged in street art workshops which resulted in two pieces of their artwork now on display at Shepshed Library.

In Melton Mowbray, young people with special educational needs worked with a professional photographer to develop their photographic and creative skills. The outcome was a film which showcased the unique character of the town.

In Oadby, families with children under the age of five were the focus of eight interactive workshops to promote an increased use of the library. Following this, the library space was adapted to create an interactive area that supports families with young children with special educational needs.

In many cases, the impact of the work was profound, with one young man returning to college to pursue a qualification in photography specifically because of his involvement in the Melton Mowbray project. His parent said, "it has given him a purpose for moving on."

Over 85% of those involved in the projects reported they will engage with future cultural activities and informed they felt more connected with their local library.

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Reduce need

What happens now

We have developed the use of technology and digital information in our services. This reduces the need for formal paid support to meet the independence outcomes of people.

Using Care Technology, when appropriate, is one way to keep a person at home for longer. This can lead to fewer hospital admissions whilst reducing the need for a person to provide the same, or similar support.

As of September 2024, our Care Technology team has received nearly 3000 referrals into the service. Of these referrals, nearly 2500 Care Technology installations have been made, which covers over 5,100 pieces of equipment. Feedback from those who have received Care Technology showed a 100% 'very satisfied' response with the service installation.

Our Occupational Therapy (OT) team promotes independence and can reduce the need for formal care services. Occupation in Occupational Therapy refers to any daily tasks that a person needs to complete. If a person is restricted in completing these 'occupations' through illness, disability, changing life circumstances or barriers within the environment, OTs can support.

Our OTs give advice and strategies for successful completion of tasks, moving and handling techniques and recommend equipment and adaptations. This all works towards maximising a person's independence whilst supporting the provision of the least restrictive, care delivery.

In 2024, our Occupational Therapy team were supporting on average 464 people per month. Following this, an average of 309 minor adaptation referrals per month were made, supporting people to be as independent as possible and reducing the need for long term support.

If a person experiences an immediate need for social care and without intervention could be at risk of needing commissioned support or even a hospital or care home admission, then our Homecare Assessment and Reablement Team (HART) can be referred to. HART will focus on a person's aims and goals whilst working in partnership with teams such as NHS Community Therapy, OTs and Care Technology, to produce a reablement plan to help the person maximise their independence.

Following this short-term intervention, a large majority of people do not need long-term support, reducing the need for formal commissioned services. In 2023 – 2024 our HART team worked through 4,300 referrals. Of these, only 10 % required ongoing long-term support or an increase to their previous care package before HART's intervention.

Community Reablement Workers in our Mental Health and Learning Disability and Autism services provide outcome focused, short-term support to re-able or enable people to be more independent.

If someone is supported by a council commissioned service (or jointly alongside the Integrated Care Board) and are experiencing behaviours of concern, our Positive Behaviour Support (PBS) team can support. The PBS service offers a person-centred approach to support which involves understanding the reasons for behaviour and supporting staff teams to create physical and social environments in which people can thrive. The PBS service currently works to reduce restrictive practice when supporting a person with behaviours of concern.

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Aims of our strategy - we will

- Continue to commit to working with our health partners, developing and providing services that support wellbeing and independence
- Target those most at risk of needing formal services and working with the person and our partners to reduce this risk
- Deliver our coordinated HART reablement and HART urgent response offer to maximise independence potential
- Offer reablement opportunities within our social care teams (through our Community Reablement Workers) to support people to achieve independence outcomes and skills they have not previously had or are currently unable to achieve
- Through an integrated approach with our health partners, reduce health inequalities for people with a Learning Disability
- Continue to develop and offer our Positive Behaviour Support service to reduce restrictive practice for people who have commissioned support from the council (or jointly with the ICB) and are experiencing behaviours of concern
- Increase the use of Care Technology to meet a person's needs, where appropriate. This will be in partnership with those involved in providing care and in settings beyond a person's home
- Continue to provide OT assessments and interventions which enable people to undertake tasks that are important to them and their wellbeing

Alex is a 27 year old man who was referred to the Learning Disability and Autism Community Reablement Worker (CRW) to support him to meet new people for social activities and look for paid employment.

Over the course of a few meetings, the CRW got to understand what was important to Alex and how best to engage him with services and organisations in his local community to maximise his independence.

The CRW supported Alex to attend a gaming group at a local community centre and provided him with travel training, using local public transport with support until Alex was confident to travel independently.

The CRW also recommended that Alex attend the Prince's Trust, to gain skills that could support him into paid employment. Alex signed up to their 12-week programme and through this, applied to a national retail chain and secured a permanent, paid job.

Alex wrote to the CRW with the following: "Hi Graeme, I am very pleased to be able to tell you that I have been offered a permanent contract, working 16 hours a week minimum. My family are so pleased for me. I have to say a huge thank you to you Graeme, without you telling me about the Prince's Trust programme I wouldn't have had the opportunities that have been given to me. I could never have thought that I would have been offered a job after going on the programme – it was too much to hope for."

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Delay need

What happens now

The Home First service provides short-term targeted intervention, supports hospital discharges, prevents admissions to hospital or long-term building-based care, responds to people in the community experiencing a social care crisis and supports recovery to maximise independence.

By working closely with partners and working within the community, including acute and non-acute hospitals, the service can delay a person needing long term support.

Our Care Co-Ordinators in the Integrated Care Team work within Leicestershire's Primary Care Networks (PCNs), which are groups of GP practices across the county. For people identified through a risk review process, the service can delay the need for more intensive health and social care support. This is achieved through early intervention and prevention, the completion of holistic assessments and multi-disciplinary team working.

The Occupational Therapy Lightbulb Team works closely in partnership with our district councils across the county, to provide complex, major adaptations for adults and children. This supports people to remain in their own home, promotes independence and delays the need for a permanent residential or nursing stay.

If someone has had a hospital stay, our teams can refer to the Housing Enablement Team (HET). This is made up of expert housing professionals who can tackle housing related issues to reduce the risk of readmission to hospital due to poor or unsuitable housing conditions.

Avoiding permanent residential or nursing placements is another indicator of delaying dependency. Our long-stay nursing or care home admission rates for people aged 65+ during 2023 – 2024, compared to 2022 – 2023, demonstrated a reduction in placements made.

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Aims of our strategy - we will

- Support the Home First agenda of keeping people in their home for as long as possible
- Continue to work alongside our health partners, such as Community Therapy, to support people to their new independence as quickly as possible
- Have a HART (Homecare Assessment and Reablement Team) service that maximises the independence of those who access the service, which will delay the need for long term care
- Have an OT service that will continue to assess for adaptations in people's homes to allow them to live at home for longer, delaying the need for specific care accommodation
- Further understand how our universal services can support with delaying the need for formal health and care services
- Expand on our Extra Care offer, enabling the schemes to meet more complex needs and growing the number of schemes across the county

James is a fiercely independent gentleman, living with Muscular Dystrophy since the age of 21. His home has been adapted, through a Disabled Facilities Grant (DFG) and this allows him to meet his care and support needs independently.

Due to difficulties with standing from a seated position, James was unable to use a standard toilet without support and this meant he was unable to use it when alone. This had a significant impact on his wellbeing and led to him needing the toilet more frequently than usual.

A referral was made to our Occupational Therapy (OT) team who completed an OT assessment and identified that a Closomat, wash and dry toilet with a vertical, toilet seat raiser would allow James to toilet independently.

An urgent DFG application was made and approved and this facilitated the installation of James' new toilet and toilet seat raiser. James is independent again and can toilet with dignity. He is able to manage the transfer on and off the toilet independently and the equipment reduces the risk of James falling whilst trying to use his facilities.

James was very happy with the outcomes of his OT referral and said the following to his Occupational Therapist. "Thank you, you have gone out of your way to get me the help I have needed. You have gone above and beyond to do all this for me, you have given me back my life and I will always be grateful."

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Meet need

What happens now

When a person's strengths, assets and available resources are working together to keep them independent but there is a still a need for support, Adult Social Care works with the person and those supporting them, to meet eligible needs.

At any given time during 2024 our Adult Social Care services were working with over 1000 people.

Everyone in receipt of long-term, community-based support should be provided with a personal budget, preferably as a Direct Payment to promote choice and control for the person. During 2023 -2024, a third of people with a personal budget took this as a Direct Payment. If there is a need for formal, paid support, the department aims to maximise all opportunities to deliver this within its available budget.

The Care Quality Commission (CQC) rating of Good or Outstanding for Leicestershire's Adult Social Care providers is in line with the national average. The department will work with providers and the CQC to maintain the quality of local provision.

The number of people that were supported with care in their home grew during, and since, the Covid-19 pandemic. In Leicestershire, we have seen a large increase in the number of people receiving home care. In response to this, we have increased the number of providers that we commission directly with, supporting the reduction of waiting lists for care and supporting a growing, home care market.

Our Young Adults with Disabilities (YAD) team supports the transition of identified young adults, living with a disability, from children's education and children's social care into adulthood.

Aims of our strategy - we will

- Continue to listen to people's experiences of Adult Social Care and make improvements to what matters to our communities
- Further develop our engagement activities to co-produce services and information with the public
- Develop new commissioning approaches which aim to develop the local care market whilst finding new models of care. Services will be affordable, of a good quality, and will keep people safe whilst delivering best value
- Engage with providers to understand the challenges that our care market faces, seeking to reduce provider instability where possible
- Work with our providers to maximise people's opportunities for independence, health and wellbeing, recognising the importance of progression for independence

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- Always promote independence through our strength-based assessments and practice and creating outcome focussed support plans. For those in receipt of services, we will identify areas for progression to seek the most independent outcome for the person
- Support our Adult Social Care teams to understand what makes a good life for the person
- Work in partnership with the Integrated Care Board (ICB) and partners to develop pathways and services to meet needs of the people in the County
- Provide commissioned services to meet eligible needs when all other support assets have been used, that are within our available budget
- Develop a sustainable approach to the ways we work whilst recognising the financial challenges the department experiences
- Continue to promote independence and improved outcomes for the people we support whilst managing the demand of our services
- Develop our personal assistant market for people of all ages, who require care
- Develop efficient and effective social care pathways to adulthood and work together with partners to deliver high quality services for eligible young adults

Karen's world was turned upside down when an accident at work resulted in a broken back, leading to her being unable to continue her career and requiring care and support to meet her social and daily living outcomes.

Following her Care Act assessment, Karen met with her social care worker to build a personalised care plan. Through her assessment, Karen informed what was important to her, what makes her happy, what strengths she can draw upon (herself and friends and family) and areas where she required some support.

Karen received support from a care agency to meet her needs, through a council managed budget but found their support not quite right for her. Karen wanted more flexibility with how her care was delivered and decided to have a Direct Payment instead. With support from Adult Social Care, she utilised her personal budget to employ her own Personal Assistants (PAs) which she would manage alongside her Direct Payment.

"My Direct Payment gives me freedom of choice of how to use my personal budget..."

This works very well for Karen and she said "my care gives me freedom and my PAs enable this. Having care needs can be quite isolating and friends can dwindle away. My Direct Payment gives me freedom of choice of how to use my personal budget, enables me to function and stops me being isolated. My PAs have built my confidence, increased my independence and opened up my world to a new normal following my accident. This gave me the motivation to get going again."

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Next steps

This strategy has been developed to provide the aims, ambitions and direction for the Adults and Communities department and will form part of the department's business planning.

Whilst delivering this strategy, we recognise this will be through a period when cost and demand pressures are being experienced across the country. The department will need to be efficient when providing services so that we are sustainable and meet the needs of the county. We are committed to keeping a focus on our finances and will maximise the effective use of our available budgets to support people in line with the aims of the strategy.

How we will monitor our success

We will use a range of measures to track our progress over the course of this strategy. Some of these will be ones we report nationally along with other local authorities and some will be local targets and measures that we will develop with those who support the delivery of this strategy.

These include:

- The invaluable feedback we receive from the public and people we work with
- The outcomes for people receiving services across the department
- Our performance relating to the statutory duties
- The Care Quality Commission's (CQC) assessment of our Adult Social Care service
- Arts Council England and The National Archives accreditation schemes
- The Visitor Attraction Quality Assurance Scheme
- Ofsted's assessment of our Adult Learning Service

The authority will continue to submit statutory national datasets, including the new Client Level Data and make use of the developing publications of this data by the Department of Health and Social Care. Furthermore, Leicestershire County Council will play an active role in regional benchmarking to help understand and improve our outcomes for people who approach the authority for advice and support.

Leicestershire County Council is also host to a National Institute of Health and Care Research (NIHR) funded Health Determinants Research Collaboration (HDRC). This collaboration aims to embed research and evidenced-based decision making into the council. The Department will work with the HDRC where possible and will aim to adopt learning from the research to ensure findings are shared in a meaningful and useful way for the wider service.

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Glossary

Word or phrase	Meaning
Adaptations	(In someone's home) Making changes or adding equipment to the home to make it easier for a person to complete their daily tasks
Adult Learning	Adult Learning means any educational activity undertaken after the age of 18
Adult Social Care	Adult social care is a system of support designed to maintain and promote the independence and wellbeing of disabled and older people, and informal carers. While often associated with the provision of personal care and support, it also includes keeping people safe, supporting people to perform parenting roles, participate in their communities and manage other day-to-day activities
Adults and Communities	This is the name of the Department within Leicestershire County Council that is responsible for adult social care, library, museum, heritage and adult learning services
Advocacy	Supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need
Apprenticeship	Combines real work with training and study
Assessment of Need	Used to identify an individual's social care and support needs and their eligibility for care and support
Assets	With reference to this strategy, assets are people, organisations, services or places that people can use to support them in their daily life. An asset-based approach refers to an individual using resources available to them in the community. This includes links to family, friends and other
Attainment	With reference to Adult Learning, attainment is the reaching of a grade when completing or finishing a course. A higher level of attainment means that the person has reached a higher grade
Bespoke	Tailored to meet an individual's needs
Biodiversity	Biodiversity is the variety of plant and animal life in the world or in a particular habitat. A high level of biodiversity is usually considered to be important and desirable.
Care Technology	This refers to technology that can assist people to do everyday activities and help them to maintain independence such as clocks that can speak the time
Charity and Voluntary Sector	In relation to public services, these are organisations who are separate from local and national government. They do not operate to just make a profit and usually focus on providing a service to solve a social need.
Collaboration	Working together with others to achieve a shared goal
Commissioning	The process of specifying, securing and monitoring services to meet people's needs. This can be done at an individual, group and strategic level. This applies to all services, whether they are provided by a local authority, NHS, other public agencies or by the private or voluntary sectors

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Word or phrase	Meaning
Community Cohesion	A term referring to communities having a sense of belonging, where: • diversity is viewed positively • there are equal opportunities for people from all backgrounds • strong, positive relationships are developed between people living in the community and local workplaces, centres, schools and neighbourhoods (LGA https://www.local.gov.uk/our-support/equalities-hub/community-cohesion-inclusion-and-equality)
Contingency	Preparing for an alternative in case a service or support that is usually in place, is not available. Or a provision for a possible event or circumstance which is possible but cannot be predicted with certainty
Co-production	When an individual/groups are involved as an equal partner(s) in designing the support and services they receive.
Criteria	A set of rules or principles that help to decide how, when or if something is completed
Cultural Participation Team	The outreach team for our Libraries and Heritage services who support local people to shape how culture is interpreted, experienced and enjoyed, by working with them to create and deliver cultural activity and resources
Demographic	How the population is made up
Deprivation of Liberty Safeguards (DoLS)	Restriction of a person's liberty to the extent that they may be deprived of their liberty – provisions of the Mental Capacity Act 2005 must be applied.
Dynamic or Dynamism	Showing progress and the ability to change if required to be successful
Economy	The productions and consumption of goods and services and supply of money within a country
Enable	To support someone to be able to complete a task
Enablement	To support someone to be able to learn a new skill, one they have not learnt before
Ethos	A set of beliefs
Family Hubs	A place where families can get advice, information and resources to support them from pregnancy, through a child's early years, later childhood and into young adulthood
HART – Home Assessment Reablement Team	The HART service help individuals to return home from hospital or prevent them from being admitted into the hospital and regain their independence, by providing urgent short-term support and intensive reablement and on behalf of the County Council by working collaboratively with service users, carers, health partners and other agencies involved in their care.
Health and Social Care integration	A programme to change how health and social care are delivered. It refers to joining services up to avoid duplication for people receiving care and support.
Heritage	Our heritage is what we have inherited from the past to value and enjoy in the present, and to preserve and pass on to future generations. It includes things we can store or physically touch, e.g. traditional clothing, buildings, artworks, tools, modes of transportation; or forms of culture without a physical form, e.g. music, dance, drama, skills, cuisine, sport, crafts, and festivals
Holistic	Including all that is important to the person. This includes their social needs, health needs, family, friends and communities
Inclusivity	Being accessible and available to all people, regardless of age, gender, race
Independence	This means being able to have autonomy to make choices and do the things you want in life. In the context of social care this can mean making decisions on where you live and the support you receive

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Word or phrase	Meaning
Information Provision	Providing information to the public about what the council can provide. This could be information about any of the services provided by the department. This information may be a leaflet but could also be a web page or an electronic document
Interpreted	How something is understood by a person
Leicestershire County Council	Leicestershire County Council is the name of the local Council
Literacy	The ability to read and write, speak and listen to communicate (https://literacytrust.org.uk)
Occupational Therapy Lightbulb Team	The Lightbulb programme is a collaboration between the County Council, district councils and other partners designed to help older and vulnerable people stay safe and well in their own home for as long as possible.
Outcomes	The benefits to an organisation or individual that result from a service or activity
Partners	Other services or organisations who work with the council to help achieve our vision and goals
Perceptions	The way that things are thought about or viewed
Prevention	Actions to prevent people's wellbeing from deteriorating by enabling them to help themselves through information and advice and community led groups.
Primary Care Networks (PCN)	GP practices are working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as primary care networks (PCNs) (NHS England)
Reablement	Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury to support them to regain their independence and maximum wellbeing.
Resilience	Being able to withstand difficulties
Safeguarding	The process of ensuring that adults at risk are not being abused, neglected, or exploited, and ensuring that people who are deemed "unsuitable" do not work with them.
Seldom Heard	With references to communities, these are groups where they may not usually interact with the council or services provided by the council.
Short term care	Care that is not long term and usually to help a person reach reablement goals. This covers our reablement services
Social Prescribing	Social Prescribing is when a GP, other health or social care professional refers or signposts an individual to local non-clinical activities or support which will help with their health and wellbeing.
Statutory	Means that there has been a law made by the UK Parliament and that there are parts of that law that need to be delivered or controlled
Strengths based approach	Strengths-based approaches focus on an individuals' strengths (including personal strengths and capital) and not on their weaknesses. (Please also see 'Assets')
Targeted Intervention	Specific support to meet a specific need
Universal Services	Universal services are those services provided to all adults, children, young people and their families from health, education and other community services
Viability	The ability for something to work successfully
Vocational	A course that focuses more on practical learning over exams

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Leicestershire County Council

Agenda Item 11

HEALTH AND WELLBEING BOARD 29 MAY 2025

REPORT OF HEALTH & WELLBEING BOARD

HEALTH & WELLBEING BOARD DEVELOPMENT SESSIONS EVALUATION

Purpose of report

1. The purpose of the report is to provide an update to the Health and Wellbeing Board (HWB) on the evaluation of the development sessions that were conducted during 2024-25. Based on these insights the report will recommend an approach for future sessions.

Recommendation

2. The Board is Requested to:

   (a) Note the feedback from the development session evaluations;

   (b) Note the recommendations and key themes that came out of the sessions;

   (c) Agree next steps for future HWB development sessions.

Background

3. Health and Wellbeing Board (HWB) development sessions are designed to enhance the effectiveness of board members in their roles. These sessions focus on building leadership skills, improving strategic decision making and fostering collaboration between partners. They also provide a space for board members to reflect on priorities, explore best practices and drive improvements in local health and wellbeing outcomes.

4. During 2024-25, five development sessions were held, covering key areas to support the effectiveness of the Health & Wellbeing Board and respective sub-groups. The sessions held were:

   - **Best Start in Life** - The focus of this session was to identify the key challenges for children and families in Leicestershire with regards to the Best Start for Life Priority of the JLHWS, what was working well

and what could be collaboratively worked through to make progress on the challenges and maximise strengths and opportunities.

- **Staying Healthy, Safe & Well** – the objective of this session was to identify what was working well within the partnership and what were the challenges, including which priorities needed greater attention.

- **Living & Supported Well** – the purpose of this session was to share an update on outcomes and achievements to date and agree the direction of travel for this priority in 2025-26.

- **Dying Well** – the aim of this session was to explore the End-of-Life current offer and its strengths and areas of development at system, place and neighbourhood.

- **Improving Mental Health** - This session provided an opportunity to understand the patient and resident journey and review overlapping priorities of other organisations to ensure alignment and prevent duplication.

5. The development sessions were facilitated by an external provider, ensuring expert guidance and a structured approach to each topic. Key stakeholders were carefully identified to help shape the agenda, ensuring that the sessions addressed the most relevant issues. Appropriate stakeholders were then invited to attend, ensuring a diverse group. Each session ran for half a day and featured a blend of presentations, discussions and tabletop activities, providing an interactive and engaging environment for all participants. This format allowed for meaningful contributions and in-depth exploration of key themes.

6. These sessions received positive feedback from participants highlighting their value in enhancing collaborations, strategic thinking, and understanding of local health priorities. Given the benefits and engagement seen throughout the year, at the Health & Wellbeing Board meeting held on 27 February 2025, the board committed to continuing these sessions on a bi-annual basis to further strengthen its impact and drive improvements in health and wellbeing outcomes.

Key Themes & Recommendations

7. During the five developments sessions held throughout 2024-25, a number of key themes emerged, reflecting the priorities and discussions of key stakeholders that attended the sessions. These themes highlight important areas of focus, including strategic collaboration, community engagement and health inequalities. Each session provided valuable insights that have shaped ongoing discussions and future planning within HWB subgroups. The themes identified are illustrated below:

- Pooling of budgets and/or resources including joint procurement opportunities;
- Improved join-up between subgroups;
- Patient Involvement, i.e. active listening;
- Data (sharing and using it effectively);
- Building resilience amongst communities;
- Engagement & communication with communities;
- Meaningful engagement of the voluntary sector;
- Behaviour-change across the partnership – systems thinking approach;
- Remove barriers from working across different organisations.

8. Over the past year, various subgroups have presented their recommendations to board, reflecting their analysis and discussions on key issues. These recommendations aim to address critical challenges and improve outcomes in specific areas of focus. The following is a summary of the recommendations put forward by the subgroups during this period, highlighting their proposed actions.

- **Staying Healthy Partnership (Staying healthy, safe & well strategic priority)** - agreed to spotlight the following priority areas. These focus areas are alongside the SHPs existing remit to monitor ('watch') and champion activity across a range of delivery areas:
  - ***Health and the Strategic Planning System*** – build on and enhance the existing collaborative work to increase awareness, and consideration of health implications and requirements within planning policy and decision making.
  - ***Healthy Weight*** – to come together and champion a whole systems approach and joint agenda and the co-ordination of resources towards healthy weight, food and nutrition.

- **Children & Family Partnership (Best start for life priority)** - agreed to prioritise the following areas and embed into the current planning process and planned reviews:
  - Transferring of data/information sharing and communication between organisations;
  - Engagement and communication with communities;
  - Workforce development, recruitment and retention;
  - Identifying opportunities for joint working or pooling of resources, including better engagement with the voluntary sector.

- **Mental Health Place-based Group (Improving mental health - cross cutting priority)** - agreed to work on improving challenges identified at the session including:
  - Role of the Health and Wellbeing Board to provide a link between system, place and neighbourhood;
  - How work takes place effectively across the sub-groups – there is no clear join up between the sub-groups around common

themes such as mental health, where there are potential overlaps with other sub-groups including the Children and Families Partnership, the Staying Healthy Partnership and Integration Executive.
    - Commitment required from all partners to communicate and challenge ways of working to effect change (through greater collaboration).
    - Help remove barriers of working across different organisations with different cultures and differing often complex governance structures.
    - The need to work effectively across system, in particular the need to work more effectively with districts and neighbourhoods with greater communication between system, place and neighbourhoods regarding priorities.
    - How to engage meaningfully with the Voluntary and Community sector.
    - Review of Joint Commissioning Group is required (sits within the Integration Executive subgroup of the Health and Wellbeing Board).
    - Strategy and commissioning at place level through joint decision-making processes.
    - Proactive early intervention and prevention.

- **Integration Executive (Living and Supported Well priority)** - agreed in 2025 to focus on key areas identified by the group which includes:
    - Prevention (80% of budget is spent on 20% of population using service) need to ensure investment is right;
    - Ensuring place-based needs are correct – targeting the right care at the right place;
    - Ensure effective use of resources e.g. pooling/sharing budgets and people;
    - Reduction in Falls/Frailty;
    - Focus on long-term conditions;
    - Promoting Independence & Self-management.

- **Integration Executive (Dying Well priority)** - agreed to follow-up actions:
    - Cross reference the place and ICB strategies and identify any gaps;
    - Identify what combined offers are possible;
    - Strengthen links with Children's Services and Voluntary Sector Organisations;
    - Align the JLHWS to LLR strategy priorities;
    - Form a reporting programme to HWB;

- Identify priority workstreams to feed into the Integration Executive.

Feedback from HWB Members

9. A survey was sent out to HWB members to gather their views on the 2024-25 development sessions, seeking feedback on their effectiveness, content and overall impact. The responses provided valuable insights into the strengths of the sessions, as well as areas for improvements. The key findings from this survey are presented in this section of the report, offering comprehensive overview of members' perspectives and to help inform future development planning.

10. In total 6 Health and Wellbeing Board members responded to the survey. Out of the 6 respondents 5 attended at least 3 development sessions.

11. HWB Board members were asked, how they would rate the development session/s. 5 respondents stated that the sessions were either good or excellent, 1 respondent stated that the sessions were satisfactory and none of the respondents stated that the sessions were poor.

12. HWB Members were asked what the key insights or takeaways from the session were. The following responses were given:

- Good group discussions sharing knowledge with each other;
- Understanding what other organisations were doing for each area;
- That there is still a gap on the VCSE being a full part of things, there is a huge role that the VCSE can play;
- An understanding of the main work and priorities of the sub-groups;
- A willingness for a system wide approach and the need to stop duplication within our systems.

13. HWB Members were asked what aspects of these sessions worked well. The following responses were provided:

- Everyone genuinely listening to each other and recognising each other's skill sets;
- The group discussions;
- The structure was good, Deborah was an excellent facilitator, good cross section of partners and also very interactive;
- Presentations from lead officers and the chance to shape the direction of the sub-groups and the HWBB.

14. HWB Members were asked what could be improved for future sessions. The following responses were provided:

- We are spending a lot of time doing developing, but it doesn't feel like we are spending time putting that development into action;
- More goal oriented;
- More time to delve and then a follow up session to review actions and progress;
- More partners attending and engaging.
- Not the sessions themselves but would want to see feedback on the outcomes of the sessions - e.g. what changed as a result of the sessions
- Outcomes - what has happened next? Highlighting what has been already achieved.

15. HWB Members were asked whether sessions were relevant to their area of work. All respondents stated that the sessions were relevant (either somewhat or very relevant) to their area of work.

16. HWB Members were asked what topics or areas they would like to see covered in future development sessions The following responses were provided:

- A lot of the important areas have been covered;
- Neighbourhood health and care; commissioning;
- Dentistry / oral health;
- Working with the VCSE and local communities;
- It would work to go through the groups again - learning more on progress made by them;
- Strengthening public and patient engagement / Co-production with service users and communities.

17. HWB Members were offered an opportunity to provide further comments or suggestions. The following responses were provided:

- Externally facilitated sessions;
- Morning sessions rather than late afternoon;

Next steps

18. Following feedback received, it is recommended that HWB development sessions are held bi-annually commencing in 2026. As a workshop for the Better Care Fund (BCF) is being scheduled for HWB members in the Autumn, coupled with commitments for JLHW Strategy review meetings, this timeline will help balance workloads, provide adequate time for preparation and the commitments within the revised strategy will also be finalised.

19. When designing future development sessions, feedback from previous sessions will be carefully considered to ensure the sessions are effective and engaging. Appropriate stakeholders will be invited to participate, ensuring relevance and diverse perspectives. The sessions will include a mix of presentations, discussions, and interactive activities to enhance engagement and learning. Where appropriate, an external facilitator will be used to bring expertise and an objective perspective. Clear session goals and objectives will be established in advance and insights from previous sessions, including outcomes and follow-up actions, will be incorporated to drive continuous improvement.

20. The specific topic areas for future development sessions will be agreed upon closer to the time to ensure they remain relevant and responsive to emerging needs. However, current suggestions gathered from session evaluations will be considered, including the role of voluntary sector organisations, neighbourhood health & care and commissioning. These topics have been highlighted as key areas of interest and will be proposed for inclusion.

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Agenda Item 12

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 29th MAY 2025

REPORT OF DIRECTOR OF ADULTS AND COMMUNITIES

BETTER CARE FUND YEAR END 2024-25 PERFORMANCE

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board (HWBB) with the year-end performance reporting of the Better Care Fund (BCF) programme for 2024-25. The report also seeks approval for the submission of the year end template which sets out income and expenditure, performance against BCF metrics, successes and challenges and statements as to whether the national conditions have been met.

Recommendation

2. It is recommended that:

   a) The performance against the Better Care Fund (BCF) outcome metrics, and the positive progress made in transforming health and care pathways in 2024-25 be noted;

   b) The year-end BCF 2024-25 template, attached as the appendix to the report, be approved for submission to NHS England for the 6th June, 2025 submission deadline;

Policy Framework and Previous Decisions

3. The BCF policy framework was introduced by the Government in 2015, with the first year of BCF plan delivery being 2015/16. The Cabinet in February 2014 authorised the Health and Wellbeing Board to approve the BCF Plan and plans arising from its use.

4. The Board received a report on work to progress the refresh of the BCF Plan for 2023-25 at its meeting on 25th May 2023.

5. The report also confirmed the different funding elements for the BCF in 2024-25, the national conditions that are required to be met, the national metrics and the demand and capacity model required.

6. The Integration Executive, a subgroup of the Health and Wellbeing Board with responsibility for the day to day delivery of the BCF, considered the draft BCF

Plan 2023-25 at its meeting on the 6 June 2023. The Executive supported its contents.

Timetable for Decisions

7. The Better Care Fund plan 2023-25 was approved by the Chief Executive of Leicestershire County Council on 27 June 2023 using delegated powers.

8. The Better Care Fund plan 2023-25 was submitted to NHSE on 27 June 2023 prior to the submission deadline of 28 June 2023

Background

9. The HWBB formally approved the BCF template for 2024-25 at its meeting on 29th February 2024, after the Chief Executive of Leicestershire County Council exercising his delegated powers in order to meet submission deadlines.

10. On 11th April 2025 the national BCF team published the year end template for reporting the position for the 2024-25 financial year which requires approval by the HWBB.

11. The aim of the report and template is to inform the HWBB of progress against integration priorities and BCF delivery. BCF quarterly reporting can be used by local areas, alongside any other information to help inform HWBs on progress with integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including integrated care boards, local authorities and service providers).

12. The completed year end template is attached as Appendix A to this report. The NHSE submission deadline is the 6th June 2025.

13. The template consists of tabs that update progress against the following:

- Whether the four national conditions detailed in the Better Care Fund planning requirements for 2024-25 continue to be met through the delivery of the plan.
- A confidence assessment on achieving the metric targets for each of the BCF metrics which includes a brief commentary outlining the challenges faced in achieving the target along with any support needs and successes that have been achieved.
- Confirms the level of income received within the HWBB area against actual expenditure and spend and activity against each of the schemes where known activity can be reported.
- Actuals against demand and capacity projections.
- Year-end feedback.

BCF Income and expenditure

14. The BCF Plan for Leicestershire for 2024/25 totals £83.2 million. This includes Disabled Facilities Grant funding of £5.5 million which has been passported to District Councils and ICB and LA allocations of the discharge grant.

15. Contributions are summarised in the table below:

BCF Plan	LLR ICB	LCC/DC	Total
ICB Minimum Contributions	51,507		51,507
Disabled Facilities Grants (DFG)		5,518	5,518
Improved Better Care Fund (iBCF)		17,691	17,691
Discharge Fund	4,356	4,134	8,490
Total Funding	**55,863**	**27,343**	**83,206**

16. It should be noted that NHS England/Improvement expectation is that all allocations are spent fully in year. Identification of underspends and overspends are for internal decision-making purposes and not external reporting.

BCF Metrics

17. The below table shows the BCF metrics for this financial year, the targets and outturns for Quarter 1 where available:

Metric	Target	Actual	Commentary
Indirectly standardised rate (ISR) of admissions per 100,000 population	162.6	195.1	The focus for the LLR system will be on the development of community care models particularly in expansion of current good performance to ensure capacity meets demand. Additional investment in neighbourhood models of care and step-up activity should mitigate the increase seen in this financial year.
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	93%	92.1%	For 25-26 an increase in RRR provision from hospital is hoped to increase further the number of people that return to their normal place of residence. This includes care home environments being supported to have residents return. There is a less than 1% variance from target to

			actual so has been reported as target met.
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	1756.9	1682.9	This metric has met the target. The falls sub-group are looking at proactive models of support in the community for falls reduction pathways along with improved performance within the DHU falls response car
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	494	583.8 (projected)	This metric is off target. Proactive care MDT's will be looking at ensuring people in high need population groups have got a care plan that will aim to support people to remain at home. This includes developing palliative care and VW service and therefore reducing the likelihood of long-term admissions to care homes.

Update against national conditions for the 2024-25 Plan

18. For 2024-25 year end reporting all national conditions have been reported as being met. For reference, these are listed below.

19. **National Condition 1: A jointly agreed plan between local health and social care commissioners, signed off by the HWBB**. For National condition 1 the documentation should outline the approach to integrated, person-centred health, social care and housing services, including:

    - Joint priorities for 2023-25
    - Approaches to joint / collaborative commissioning
    - How BCF funded services are supporting our approach to continued integration of health and social care. Briefly describe any changes to the services being commissioned 2023-25 and how they will support further improvement of outcomes for people with care and support needs

20. **National Condition 2 – Enabling people to stay well, safe and independent at home for longer**. For national condition 2 the documentation needs to show how areas have agreed how the services they are commissioning will support people to remain independent for longer and where possible to support them to remain in their own home.

21. **National Condition 3 – Provide the right care in the right place at the right time**. Areas should agree how the services they commission will support people to receive the right care in the right place at the right time and BCF

Plans should set out how ICB and social care commissioners will continue to do this.

22. **National Condition 4** – Maintaining NHS's contribution to Adult Social Care and investment in NHS commissioned out of hospital services. For both years of the Plan, the minimum expected expenditure will be uplifted by 5.66%.

Demand and Capacity modelling

23. All systems must submit a high-level overview of demand for intermediate care and planned capacity to meet this demand alongside their BCF plans. The content of capacity and demand plans now forms part of the assurance and approval process.

24. For 2024-25, it was requested that demand and capacity models be refreshed to ensure that this is being measured correctly against outturns. Data on capacity and demand throughout quarter 4 can be found on the attached planning template.

Circulation under the Local Issues Alert Procedure

25. None

Background papers

Better Care Fund Policy Framework and Planning Guidance Addendum 2024-25
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Fund Policy Framework 2023-25:
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

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List of Appendices

Appendix A – Year End Template 2024-25

Relevant Impact Assessments

Equality and Human Rights Implications

26. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

27. An equalities and human rights impact assessment has been undertaken which is provided at http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf.

    This concluded that the BCF will have a neutral impact on equalities and human rights.

28. A review of the assessment was undertaken as part of the BCF submission for 2021.

Partnership Working and associated issues

29. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

30. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integration Executive's terms of reference which have been approved by the Health and Wellbeing Board.

31. The delivery of the Leicestershire BCF ensures that several key integrated services are in place and contributing to the system wide changes being implemented through the five-year plan to transform health and care in Leicestershire, known as the Sustainability and Transformation Partnerships http://www.bettercareleicester.nhs.uk/

Better Care Fund 2024-25 EOY Reporting Template

0

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

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In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the second quarter of 2024-25 has been pre-populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- Target met
- Target not met
- Data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns L and M only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.

Activity
For reporting across 24/25 we are asking HWBs to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D Actual Activity".

5.1 C&D Guidance & Assumptions

Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the quarter, and any support needs particularly for managing winter demand and ongoing data issues.

5.2 C&D Actual Activity

Please provide actual activity figures for this quarter, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.

Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

6. Income

This section require confirmation of actual income received in 2024-25 across each fund.

- Please confirm the total HWB level actual BCF pooled income for 2024-25 by reporting any changes to the planned additional contributions by LAs and NHS as reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ADF via LA and ICB if this has changed.
- The template will automatically pre-populate the planned income in 2024-25 from BCF plans, including additional contributions.

7. Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.

The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure to date alongside percentage spend of total allocation.

Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation. Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation. This shouldn't include spend which has already been allocated in-year and should be the net position.

Underspend - Where there is an underspend please provide details as to the reasons for the underspend.

Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 7a.

8. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2024-25 through a set of survey questions

These questions are kept consistent from year to year to provide a time series.

The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of yes/no responses:

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2024-25
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

https://www.scie.org.uk/integrated-care/logic-model-for-integrated-care/#enablers

Please highlight:

4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2024-25.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2024-25.

Please provide narrative for the above 2 questions.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

HM Government

NHS England

Better Care Fund 2024-25 EOY Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Leicestershire
Completed by:	Lisa Carter
E-mail:	Lisa.Carter@leics.gov.uk
Contact number:	1163050786
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

5.2 C&D Actual Activity	Yes	
6. Income actual	Yes	
7b. Expenditure	Yes	Expenditure Underspent or Overspent
8. Year End Feedback	Yes	

[<< Link to the Guidance sheet]

^^ Link back to top

Better Care Fund 2024-25 EOY Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Leicestershire

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

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Better Care Fund 2024-25 EOY Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Leicestershire

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q3 (For Q4 data,please refer to data pack on BCX)	Assessment of whether ambitions have been met	Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans - **ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	165.1	163.5	161.8	160.2	199.9	Target not met	Demand continues to rise nationally for emergency care, however, the system will support with development of community care models.	BCF funding has supported development of crisis support services howver, this will be futher invested in in 25-26 to meet demand. Additionally, intermediate care and virtual wards will be focused on step-up and admission avoidance in 25-26.	The data for 24-25 shows that the target was missed by approximately 32 people per 100,000 population. Recognising national trends in increasing admissions may have meant that the target was too ambitious to achieve in the current climate of demand.	The focus for the LLR system will be on the development of community care models particularly in expansion of current good performance to ensure capacity meets demand. Additional investment in neighbourhood models of care and step-up activity should mitigate the increase seen in this financial year.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.7%	92.6%	95.1%	91.7%	92.22%	Target met	Challenges around meeting demand for discharge to assess beds are being looked at with colleagues across the region. With the LLR HD model being a fore runner of best practice for cohorts with high needs	BCF funding has supported the intermediate care model which has increased capacity in home care services ensuring more people go home. In turn discharging to bedded community care has also helped to ensure as many people return home after a period of RRR as possible	There is a 0.9% variance from plan.	For 25-26 an increase in RRR provision from hospital is hoped to increase further the number of people that return to their normal place of residence. This includes care home environments being supported to have residents return.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,756.9	388.4	Target met	Challenges remain on reducing admissions overall however, focused work on admissions due to falls from care homes has helped to support the delivery of this metric	Q4 data shows that this metric was projected to be met with a performance of 1682.9. Focus on crisis response services in the community and care home admissions has helped to reduce the numbers of faller	There is an approximate 3% improvement on the planned target	Focus on reducing admisisons and retianing and expanding schemes such as the falls response car aim to improve this metric further in 25-26	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				494	not applicable	Target not met	Challenges around changes to population data make this target hard to set and measure performance against. If this could be standardised nationally at the start of the finiancial year before targets are set it woud be beneficial to systems	Work to prevent long term admissions from hospitals has had performance improved however, increased community admissions have increased performance. Proactive care work on PNG 9/10/11 will better suport people and carers at home before crisis point	The plan was a rate of 494 per 100,000 population based on an actual admissions figure of 798. The outturn is 583.8 per 100,000 based on 899 admissions (and a smaller population figure of 153,982 from ONS MYE 2023)	Proactive care MDT's looking at ensuring people in high need population groups have got a care plan will aim to support people to remain at home. This includes developing palliative care and VW services	Yes

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Better Care Fund 2024-25 EOY Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Leicestershire

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
Short term packages of care to support discharge has changed since plan submisson. Within the submission numbers that supported reablement capacity rejections was inputted into short term dom-care spot purchased packages. This is now reported against spot-purchased packages for reablement. The numbers for spot-purchased capacity is due to increased demand into HART reablement team. This was built to have a capacity of 87 starts a week this is now up to an average of 111 starts per week for quarter 4. Demand has increased from the last quarter. To meet the current demand levels, the service would need to have capacity for 166 starts per week. Expansion is ongoing to accommodate this. Where capacity is not found in reablement the demand is met through domicilliary care with a review in the first two weeks if reablement capacity has not been found by this point. This team is also funded in part through the discharge grant to support increased demand for P1 services. Demand for P1 services other than reablement or rehab has significantly reduced through the year and from original demand projections (by approx 40%). Demand for P2 bedded care is also below projected demand despite additional activity usually seen during the winter months. Demand for services is also below that projected in the plan for step-up and community based services.	Yes
2. Do you have any capacity concerns for 25-26? Please consider both your community capacity and hospital discharge capacity.	
Capacity within HART reablement services remains a challenge for 25-26. Recruitment to meet the demand is slower than increases in people requiring the service. This is particularly shown in the last quarter of the year where the need for 166 starts per week was recorded in a service capcity of 111 starts. This is for both discharge and community. Capacity shortfalls to provide all patients being dicharged into a RRR D2A bed is also a concern for 25-26. The current commissioned space will provide two thirds of the analysed gap within this financial year but still requires an additional 38 beds to meet need. In addition there are step-up demands for RRR bedded care that require taking into consideration.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
Within reablement services, people are supported to leave hospital by dom care providers and a two-week review team as well as daily checks for capacity in HART reablement for each capacity rejection. People are still supported at home with teams to support, funded through the BCF where there is a shortfall. This does not increase delays in discharging patients. The frailty SDEC works to avoid hospital admissions where step-up care is needed and is supported by HART urgents team that works within ED to support same day care at home avoifing admissions. There is also a small provision of community hospital beds that are for the purpose of providing a therapy model of care for short-periods while people are recovering from a period of high care need. This is looking to be expanded as part of the ongoing plans for intermediate care. This improves on the 24-25 reporting period where intermediate care focussed on the provision of step-down services.	Yes
4. Do you have any specific support needs to raise? Please consider any priorities for planning readiness for 25/26.	
	No

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF.. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Complete:

Better Care Fund 2024-25 EOY Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Leicestershire

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			Checklist Complete:
Service Area	**Metric**	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-25**	**Feb-25**	**Mar-25**	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	782	747	733	571	549	542	143	130	221	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	2	2	2	1	1	1				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	10	47	54	0	0	0	80	44	32	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	296	250	254	196	176	174	90	77	66	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	1	1	2	2	2				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	9	9	9	15	13	12	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	19	20	23	0	0	0	9	8	5	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	1	1	14	14	14				Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan			Actual activity:			
Service Area	**Metric**	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-25**	**Feb-25**	**Mar-25**	
Social support (including VCS)	Monthly activity. Number of new clients.	306	306	306	233	231	234	Yes
Urgent Community Response	Monthly activity. Number of new clients.	723	723	723	704	542	550	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	1057	972	931	970	837	875	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	99	112	107	209	101	178	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes

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Better Care Fund 2024-25 EOY Reporting Template

6. Income actual

Selected Health and Wellbeing Board: Leicestershire

	2024-25			
Source of Funding	Planned Income	Actual income	Carried from previous year (23-24)	Actual total income (Column D + E)
DFG	£4,850,818	£5,518,288	£0	£5,518,288
Minimum NHS Contribution	£51,507,543	£51,507,543		£51,507,543
iBCF	£17,690,614	£17,690,614		£17,690,614
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£4,133,661	£4,133,661		£4,133,661
ICB Discharge Funding	£4,355,513	£4,355,513		£4,355,513
Total	**£82,538,149**			**£83,205,619**

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

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See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 EOY Reporting Template

To Add New Schemes

7b. Expenditure

Selected Health and Wellbeing Board: Leicestershire

	2024-25					
Running Balances	Income	Expenditure to date	Percentage spent	Balance		**If underspent, please provide reasons**
DFG	£5,518,288	£4,470,849	81.02%	£1,047,439	Underspent!	Additional funds announced in January 2025 of £670k. Individual scheme variances are explained in the table below.
Minimum NHS Contribution	£51,507,543	£51,507,543	100.00%	£0		
iBCF	£17,690,614	£17,690,614	100.00%	£0		
Additional LA Contribution	£0	£0		£0		
Additional NHS Contribution	£0	£0		£0		
Local Authority Discharge Funding	£4,133,661	£4,133,661	100.00%	£0		
ICB Discharge Funding	£4,355,513	£4,355,513	100.00%	£0		
Total	**£83,205,619**	**£82,158,180**	**98.74%**	**£1,047,439**	Underspent!	

Required Spend

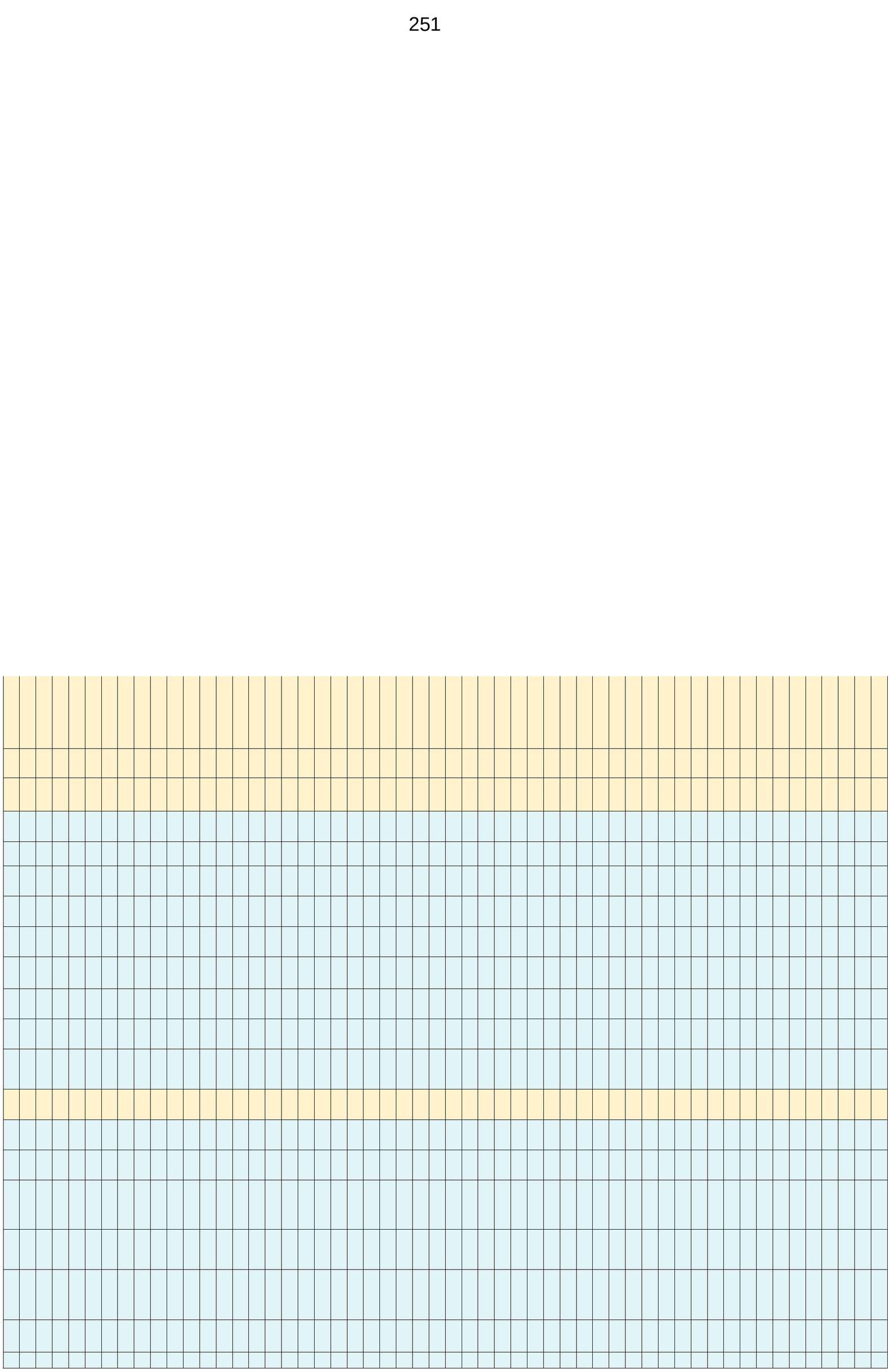
This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

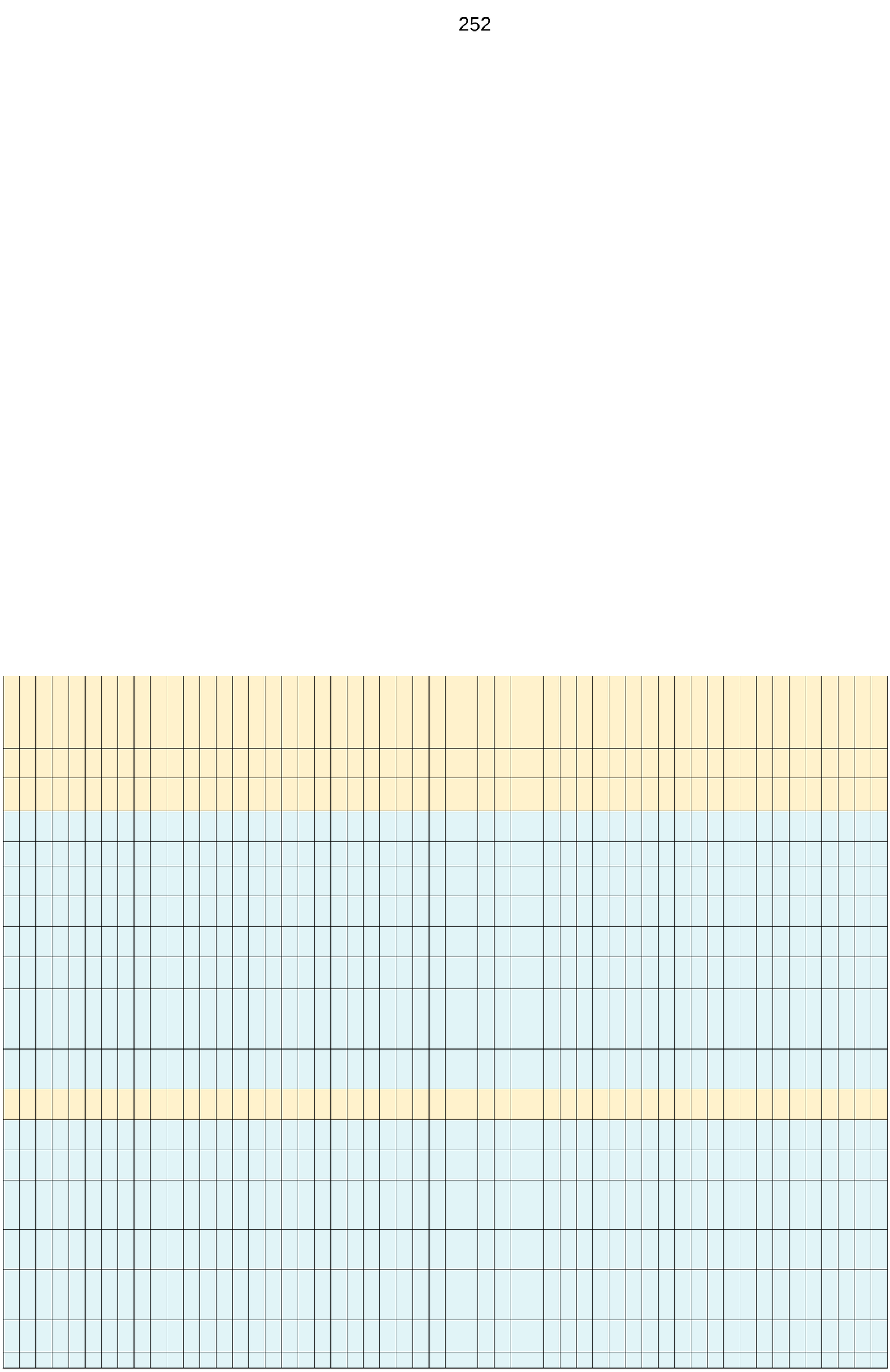
	2024-25		
	Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£14,633,036	£20,741,516	£0
Adult Social Care services spend from the minimum ICB allocations	£30,774,296	£31,387,704	£0

Checklist Column complete: Yes Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Actual Spend (£)	Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent)	Comments
1	Provision for enhanced carer support services	Support to Carers	Carers Services	Carer advice and support related to Care Act duties		600	1103	Beneficiaries	Social Care	0	LA			Local Authority	iBCF	£ 233,730	£223,000		
2	Care Homes Support / Trusted Assessor	Discharge to Assess	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		1084	416		Social Care	0	LA			Local Authority	iBCF	£ 190,750	£184,185		
3	CHC Commissioning Capacity	Discharge to Assess	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care	0	LA			Local Authority	iBCF	£ 183,750	£181,003		
4	Case managers for TCP to support inpatient	Transforming Care Programme	Integrated Care Planning and Navigation	Care navigation and planning		0	0		Social Care	0	LA			Local Authority	iBCF	£ 127,407	£0		
5	Multi-disciplinary review team for top 100 high cost	Integrated Care Planning	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care	0	LA			Local Authority	iBCF	£ 248,850	£248,850		
6	Stabilising the social care provider market	Care Providers- Market Stabilisation	Home Care or Domiciliary Care	Domiciliary care packages		586822	643052	Hours of care (Unless short-term in which case it is packages)	Social Care	0	LA			Private Sector	iBCF	£ 14,224,565	£15,536,140		
7	Development of External Workforce	Promotion of Care Work	Workforce recruitment and retention			0	0	WTE's gained	Social Care	0	LA			Local Authority	iBCF	£ 241,112	£241,110		
8	Health and Social Care Integration Programme	Integration Planning	Enablers for Integration	Programme management		0	0		Social Care	0	LA			Local Authority	iBCF	£ 224,500	£0		
9	Technology Enabled Care	Technology Services	Assistive Technologies and Equipment	Assistive technologies including telecare		860	714	Number of beneficiaries	Social Care	0	LA			Local Authority	iBCF	£ 1,214,000	£733,526		
10	Integration Programme Management	Integration Planning	Enablers for Integration	Programme management			0		Social Care	0	LA			Local Authority	iBCF	£ 57,500	£0		Spend has been incorporated into line 38
13	Single Handed Care Team	Integration Planning	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care	0	LA			Local Authority	iBCF	£ 365,400	£342,800		
14	Home First Case Management	Home First	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 612,365	£695,350		
15	HC4L Back Office Support	Home First	Enablers for Integration	Joint commissioning infrastructure			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 131,868	£131,869		
16	HART Reablement	Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		5251	4435	Packages	Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 930,088	£1,719,643		
17	Care Coordination	Integrated Care Planning	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 810,321	£724,160		
18	Care Coordination - OT	Integrated Care Planning	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 54,473	£54,470		
19	Home First Case Management (Hosp Link	Discharge to Assess	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 451,408	£451,410		
20	Home First Integrated Reablement	Discharge to Assess	Enablers for Integration	Integrated models of provision			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 544,643	£544,640		
21	Community Response Service - including	Discharge to Assess	Urgent Community Response				0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 960,301	£0		
22	Lightbulb - Housing (Discharge)	Discharge to Assess	High Impact Change Model for Managing Transfer of Care	Housing and related services			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 128,000	£114,000		
23	Positive Behaviour Support Team	Transforming Care Programme	Personalised Care at Home	Mental health /wellbeing			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 112,962	£112,960		
24	Enhanced TCP Training Wraparound	Transforming Care Programme	Personalised Care at Home	Mental health /wellbeing			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 70,288	£70,290		
25	Transforming Care Programme - Implementing	Transforming Care Programme	Personalised Care at Home	Mental health /wellbeing			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 77,047	£77,050		
26	Improving Mental Health Discharge	Mental Health	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 361,726	£374,000		
27	LD Lead Commissioning Arrangements	Mental Health	Enablers for Integration	Joint commissioning infrastructure			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 173,209	£173,210		
28	Care Act Enablers	Care Act Services	Care Act Implementation Related Duties	Other	Carer Advice and Support		0		Social Care	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 93,548	£93,550		
29	Care Act Support Pathway	Care Act Services	Care Act Implementation Related Duties	Other	Carer Advice and Support		0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 582,490	£582,490		
30	Assessment and Review (ASC protected)	Integrated Care Planning	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 2,155,667	£2,155,660		
31	Home Care Service (ASC protected)	Care Services	Home Care or Domiciliary Care	Domiciliary care packages		632215	623483	Hours of care (Unless short-term in which case it is packages)	Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 15,063,361	£15,063,360		
32	Nursing Care Packages (ASC protected)	Care Services	Residential Placements	Nursing home		82	87	Number of beds	Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 4,731,321	£4,731,320		
33	Residential Respite Service (ASC protected)	Care Services	Carers Services	Respite services		140	151	Beneficiaries	Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 976,156	£976,160		
34	First Contact Plus	Early Intervention	Prevention / Early Intervention	Social Prescribing			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 199,116	£199,120		
35	Integrated Personal Care Framework	Training Delivery	Enablers for Integration	Workforce development			0		Community Health	0	LA			Local Authority	Minimum NHS Contribution	£ 81,400	£81,400		
36	Post Diagnostic Community & In-Reach Service for	Mental Health	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			0		Mental Health	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 281,426	£281,426		
37	Improving Quality in Care Homes	Care Quality and Safeguarding	Care Act Implementation Related Duties	Safeguarding			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 708,291	£718,930		
38	Integration Programme Management	Integration Planning	Enablers for Integration	Programme management			0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 474,551	£639,559		
39	Blaby District Council	Integrated Blaby Planning	DFG Related Schemes	Adaptations, including statutory DFG grants		85	75	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 603,345	£778,882		DFG delivery has been stable in Blaby District and things appear to only have slowed down slightly due to complexity of
40	Charnwood Council	Integrated Charnwood Planning	DFG Related Schemes	Adaptations, including statutory DFG grants		48	84	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 1,108,147	£673,545		DFG Delivery has been at a good level and have delivered more than expected
41	Harborough Council	Integrated Harborough Planning	DFG Related Schemes	Adaptations, including statutory DFG grants		70	56	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 438,163	£586,882		It was predicted by Q2 that funding would be used in full before end of the financial year there is a slight overspend which will

42	Hinckley and Bosworth Distrct Council	Integrated Hinckley Planning	DFG Related Schemes	Adaptations, including statutory DFG grants		57	28	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 510,774	£331,750		Due to long term absence there was an under delivery of DFG's in the Hinckley area, we have now recruited to the vacant
43	Melton Council	Integrated Melton Planning	DFG Related Schemes	Adaptations, including statutory DFG grants		42	29	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 255,293	£289,457		The complexity of the case has increased in Melton including an increase in child cases which has resulted in a reduction on
44	North West Leicestershire Council	Integrated North Planning	DFG Related Schemes	Adaptations, including statutory DFG grants		78	63	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 708,897	£623,934		Expected and stable delivery of DFG's in NWL, we are recruiting another technical officer for NWL so we expect delivery to
45	Oadby and Wigston Council	Integrated Oadby Planning	DFG Related Schemes	Adaptations, including statutory DFG grants		54	52	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 381,299	£549,812		As with NWL and BDC, we have stable delivery in Oadby and Wigston of DFG cases.
46	Hoarding Project	Integrated Hoarding Planning	DFG Related Schemes	Discretionary use of DFG		117	94	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 385,000	£355,272		The team have also been working to support other agencies looking to replicate this project.
47	Extending Housing Occupational	Integrated EHOT Planning	DFG Related Schemes	Discretionary use of DFG		0	0	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 56,000	£0	discontinue	This pilot has now ended and the money unspent will be carried over to 25/26 to support future pilots across all districts
49	Respiratory Illness across LLR Project	Integrated Respiratory Illness	DFG Related Schemes	Discretionary use of DFG		0	81	Number of adaptations funded/people	Social Care	0	LA			Local Authority	DFG	£ 147,000	£122,238		28 front line officers have had training as part of this scheme
50	Intake Model	Intake Model design and integration	Home-based intermediate care services	Reablement at home (to support discharge)		3898	2554	Packages	Social Care	0	LA			Local Authority	Local Authority Discharge	£ 1,947,979	£961,199		
51	Home First, Nursing & Therapies	Home First	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 5,409,670	£5,409,670		
52	Home Visiting Service	Home First	Personalised Care at Home	Physical health/wellbeing		0	0		Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 2,687,197	£2,687,197		
53	Night Nursing Service	Home First	Personalised Care at Home	Physical health/wellbeing		0	0		Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 468,543	£468,543		
54	Integrated Community Nursing	Integrated Planning	Personalised Care at Home	Physical health/wellbeing		0	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 7,001,576	£7,001,576		
55	Discharge Pathway 3 Contract	Discharge to Assess	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		560	560	Number of placements	Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 599,108	£599,108		
56	Discharge Hub	Discharge to Assess	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess		0	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 326,806	£326,806		
57	Primary Care Coordinator	Discharge to Assess	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 225,100	£225,100		
58	LD Short Breaks	Mental Health	Carers Services	Respite services		133	133	Beneficiaries	Social Care	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 984,503	£984,503		
59	Post Diagnostic Community & In-Reach Service for	Mental Health	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Mental Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 66,452	£66,452		
60	LLR Community Integrated Neurology &	Care Services	Home-based intermediate care services	Rehabilitation at home (to support discharge)		0	0	Packages	Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 328,214	£328,214		
61	Loughborough Urgent Treatment Centre	Urgent Care	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess		0	0		Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 1,373,097	£1,373,097		
62	Urgent Care Centres (ELRCCG)	Urgent Care	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess		0	0		Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 1,271,250	£1,271,250		
63	Primary Care Funding to support D2A	Discharge to Assess	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	0		Primary Care	0	NHS			NHS Community Provider	ICB Discharge Funding	£ 131,840	£131,840		
64	Case management of HD cohort via MLCSU	CM capacity to support discharge	Residential Placements	Short-term residential/nursing care for someone likely to require a		106	106	Number of beds	Continuing Care	0	NHS			Private Sector	ICB Discharge Funding	£ 101,310	£101,310		
65	Blocked booked HD beds (6)	High Dependancy 1-2-1	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		180	180	Number of placements	Continuing Care	0	NHS			Private Sector	ICB Discharge Funding	£ 579,076	£579,076		
66	HD 1-1s for blocked booked beds	High Dependancy 1-2-1	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		180	180	Number of placements	Continuing Care	0	NHS			NHS Community Provider	ICB Discharge Funding	£ 235,894	£235,894		
69	Continuation & growth of the Bariatric pilot (3	Discharge to Assess	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		120	120	Number of placements	Community Health	0	NHS			Private Sector	ICB Discharge Funding	£ 731,573	£731,573		
70	HET Expansion	Capital funds for housing team to facilitate discharge	Housing Related Schemes				2160		Other	0	LA			Local Authority	ICB Discharge Funding	£ 165,760	£165,760		
71	RVS Discharge Support	RVS to support County Patients for discharges	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess			0		Other	0	NHS			Charity / Voluntary Sector	ICB Discharge Funding	£ 108,000	£108,000		
73	Training	Training and Comms on Home First	Enablers for Integration	Workforce development			0		Other	0	Joint	0.5	0.5	Local Authority	ICB Discharge Funding	£ 5,387	£5,387		
75	MH Relationship Enabler Officer	Mental Health	Care Act Implementation Related Duties	Independent Mental Health Advocacy			0		Mental Health	0	LA			NHS Mental Health Provider	ICB Discharge Funding	£ 45,000	£45,000		
76	MH S1 Unit	Systemone module to track Mental Health patients through the system	Enablers for Integration	System IT Interoperability		0	0		Mental Health	0	NHS			NHS Community Provider	ICB Discharge Funding	£ 3,500	£3,500		
79	Assertive Inreach Mental Health	Mental Health	Care Act Implementation Related Duties	Independent Mental Health Advocacy			0		Mental Health	0	LA			Local Authority	Local Authority Discharge	£ 205,000	£36,648		
80	Social Workers	Social Workers to support discharge	Care Act Implementation Related Duties	Independent Mental Health Advocacy			0		Social Care	0	LA			NHS Mental Health Provider	Local Authority Discharge	£ 157,500	£161,425		
81	CSW In hospital Team	CSW for mental health support in the community	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Mental Health	0	LA			Local Authority	Local Authority Discharge	£ 89,000	£89,000		
82	Technology enabled care	Expansion of care technology service	Assistive Technologies and Equipment	Assistive technologies including telecare		215	215	Number of beneficiaries	Social Care	0	LA			Local Authority	Local Authority Discharge	£ 310,247	£312,261		
83	Administration	Administration	Other			0	0		Social Care	0	LA			Local Authority	Local Authority Discharge	£ 82,673	£82,673		
84	Brokerage	Increased capacity in brokerage team	Integrated Care Planning and Navigation	Care navigation and planning		0	0		Social Care	0	LA			Local Authority	Local Authority Discharge	£ 219,749	£232,400		
85	Case Managers	Care Assessments	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care	0	LA			Local Authority	Local Authority Discharge	£ 321,331	£212,500		
87	Flow Improvement Team	Supporting discharge in hospitals and promoting reablement	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs			0		Social Care	0	LA			Local Authority	Local Authority Discharge	£ 626,500	£488,599		
88	System Discharge Support	System Discharge Support (Planning in progress)	Other			0	0		Community Health	0	NHS			NHS	ICB Discharge Funding	£ 1,160,000	£1,160,000		
89	Community Response Service	Urgent Community Response	Urgent Community Response	0	0	309	388		Social Care	0	LA	0		Local Authority	iBCF	£ 379,050	£0		
90	Assistive Technology and Dementia Pilot	Assistive Technologies and Equipment	DFG Related Schemes	Discretionary use of DFG	0	1235	1950	Number of adaptations funded/people	Social Care	0	LA	0		Local Authority	DFG	£ 256,900	£159,077		Currently undertaking a full-service review with regards to how the project moves forward.
91	Home first team support workers	High Impact Change Model for Managing Transfer of Care	Personalised Care at Home	Physical health/wellbeing	0	0	0		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 62,964	£62,964		
92	D2A Programme Manager	High Impact Change Model for Managing Transfer of Care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step	0	0	0	Number of placements	Social Care	0	LA	0		NHS Community Provider	Local Authority Discharge	£ 50,000	£50,065		
93	D2A review Team Manager	High Impact Change Model for Managing Transfer of Care	0	0	0	0	0		0	0	0	0		Local Authority	Local Authority Discharge	£ 60,718	£65,150		
94	D2A HD GP support	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded	0	0	0	0	0		0	0	0	0		NHS	ICB Discharge Funding	£ 44,238	£44,238		
95	Extra care short-term packages	Residential Placements	0	0	0	0	0		0	0	0	0		Local Authority	ICB Discharge Funding	£ 61,935	£61,935		
96	Health care task training	Home Care or Domiciliary Care	0	0	0	0	0		0	0	0	0		NHS Community Provider	ICB Discharge Funding	£ 100,000	£100,000		
97	Lead commissioner post	Enablers for Integration	0	0	0	0	0		0	0	0	0		Local Authority	ICB Discharge Funding	£ 82,000	£82,000		
98	Care packages to support HART capacity	Home Care or Domiciliary Care	0	0	0	0	1374		0	0	0	0		Private Sector	ICB Discharge Funding	£ 800,000	£800,000		
99	Care packages to support HART capacity	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Short term domiciliary care (without reablement input)	0	301	92	Hours of care (Unless short-term in which case it is packages)	Community Health	0	LA	0		Private Sector	Local Authority Discharge	£ -	£52,081		
100	System Discharge Support	System Discharge Support (Planning in progress)	Other	0	0	0	0		Community Health	0	NHS	0		NHS	Local Authority Discharge	£ -	£564,786		





Adding New Schemes:

Back to top

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number)	Units (auto-populated)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	Planned Expenditure (£)	Expenditure to date (£)
101	Interim Beds	Short stay for D2A placements	Residential Placements	Short-term residential/nursing care for someone likely to require a		0	145	Number of beds	Social Care		LA			Private Sector	Local Authority Discharge		£431,771
102	Agency staff to support discharge	Teams in care pathway supported by additionalo agency staff for discharges	Workforce recruitment and retention	Additional or redeployed capacity from current care workers		0	3	WTE's gained	Social Care		LA			Local Authority	Local Authority Discharge		£192,432
103	Transforming Care Programme	2 SW posts to support transforming care service users	Workforce recruitment and retention	Additional or redeployed capacity from current care workers		0	2	WTE's gained	Social Care		LA			Local Authority	Local Authority Discharge		£133,769
104	SystemOne Licenses	To support staff with ongoing S1 licences for discharge hub	Enablers for Integration	System IT Interoperability					Social Care		LA			NHS Community Provider	Local Authority Discharge		£3,938

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Better Care Fund 2024-25 EOY Reporting Template

8. Year End Impact Summary

Selected Health and Wellbeing Board: Leicestershire

Confirmation of Statements			Checklist Complete:
Question statements	**Confirmation**	**If the answer is "No" please provide an explanation:**	
Overall delivery of BCF has improved joint working between health and social care	Yes		Yes
Our BCF schemes were implemented as planned in 2024-25	Yes		Yes
The delivery of our BCF plan 2024-25 has had a positive impact on the integration of health and social care in our locality.	Yes		Yes

Highlight success and challenges within reference to the most relevant enablers from SCIE logic model:		
Logic model for integrated care - SCIE		
Success and Challenges	**Narrative**	
2 key successes observed towards driving the enablers for integration	Intermediate Care programme over the last two years has shown marked improved performance in areas of step-up and step-down with particular areas of work such as the commissioning of High Dependency Beds recieving national recognition. Integrated therapy and reablement teams in localities has helped to reduce duplication, improved relationships and improved timescales and outcomes for people recieving support in community settings. This also forms a blueprint for neighbourhood models of care in the 25-26 plan.	Yes
2 key challenges observed towards driving the enablers for integration	Recruitment to meet demand for certain services remaind a challenge across the system. This is despite investment. To mitigate investment in other teams has helped to bridge any gaps in cpacity to ensure services are as equitable as possible. D2A bedded capacity away from sot-purchasing remains a challenge for the system that will be mitigated in part in 25-26. However, funding to manage the remainder of the demand is going to prove challenging to provide a RRR model for 4 weeks for all who are assessed as needing this type of support.	Yes

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Agenda Item 13

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 29 MAY 2025

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

LEICESTERSHIRE BETTER CARE FUND PLAN 2025/26

Purpose of report

1. The purpose of this report is to inform the Health and Wellbeing Board regarding the final Leicestershire Better Care Fund (BCF) Plan for 2025/26.

Recommendation

2. The Board is recommended to:

   (a) Note the Leicestershire Better Care Fund (BCF) Plan 2025/26, including the Planning Template, Demand and Capacity template and Narrative document;

   (b) Note the action taken by the Chief Executive of Leicestershire County Council, following consultation with the Chairman of the Health and Wellbeing Board, to approve the BCF Year 25-26 report and use powers of delegation to approve this by the NHS England submission deadline of 31st March 2025.

Policy Framework and Previous Decisions

3. The BCF policy framework was introduced by the Government in 2015, with the first year of BCF plan delivery being 2015/16. The Cabinet in February 2014 authorised the Health and Wellbeing Board to approve the BCF Plan and plans arising from its use.

4. The Board received a report on work to progress the refresh of the BCF Plan for 2025/26 at its meeting on 27th February 2025.

5. The report also confirmed the different funding elements for the BCF in 2025/26, the national conditions that are required to be met, the national metrics and the demand and capacity modelling required along with a draft narrative.

6. The Integration Executive, a subgroup of the Health and Wellbeing Board with responsibility for the day-to-day delivery of the BCF, considered the draft BCF Plan 2025/26 at its meeting on the 4th March, 2025. The Executive supported its contents.

Timetable for Decisions

7. The Better Care Fund plan 2025/26 was approved by the Chief Executive of Leicestershire County Council on 27th March, 2025 using delegated powers.

8. The Better Care Fund plan 2025/26 was submitted to NHSE on 27th March 2025 prior to the submission deadline of 31st March 2025.

Background

9. The BCF programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. It represents a unique collaboration between:
    - The Department of Health and Social Care;
    - Ministry of Housing, Communities and Local Government;
    - NHS England and Improvement;
    - The Local Government Association.

10. The four partners work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the NHS Long Term Plan. https://www.england.nhs.uk/long-term-plan/ Locally, the programme spans both the NHS and local government to join up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

11. Launched in 2015, the programme established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:
    - minimum allocation from NHS clinical commissioning group(s) (CCGs);
    - disabled facilities grant – local authority grant;
    - social care funding (improved BCF) – local authority grant;
    - winter pressures grant funding £240 million – local authority grant.

BCF Plan for 2025/26

12. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance of spending in line with the national conditions of the Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

13. The BCF Plan consists of the expenditure plan, narrative, outcome metrics and demand and capacity modelling.

14. A narrative template is made available for local authority areas to use to describe how the national conditions relating to the BCF will be met. A copy of this is attached as Appendix A to this report. The narrative document also has four appendices attached to it for information, labelled A to D.

15. An excel template is made available for areas to use to record and agree spending in local BCF plans, named the BCF Expenditure Plan. A copy is included as Appendix B. This is intended to support local planning and also reporting at year end. It includes targets and current data against the national metrics included in the requirements.

BCF National Conditions

16. The national conditions set by the Government in the policy framework for 2025/26 are:

- **National Condition 1 - Plans to be jointly agreed.** Local authorities and Integrated Care Boards (ICBs) must agree a joint plan, signed off by the Health and Wellbeing Board (HWB), to support the policy objectives of the BCF for 2025 to 2026. The development of these plans must involve joint working with local NHS trusts, social care providers, voluntary and community service partners and local housing authorities. These plans must be submitted to BCF national and regional teams and must include locally agreed goals against these 3 headline metrics (see below) and an intermediate care capacity and demand plan.

- **National Condition 2 – Implementing the objectives of the Better Care Fund**
  Local authorities and ICBs must, in their joint HWB plans, show how health and social care services will support improved outcomes against the fund's 2 principal policy objectives:
    - To support the shift from sickness to prevention – including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.
    - To support people living independently and the shift from hospital to home – including help prevent avoidable hospital admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of residence); and reduce the proportion of people who need long-term residential or nursing home care**.**

- **National Condition 3 – Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care.** The NHS minimum contribution to adult social care must be met and maintained by the ICB and will be required to increase by at least 3.9% in each HWB area. Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and of the Disabled Facilities Grant. HWB plans will also be subject to a minimum expectation of spending on adult social care, which are published alongside the BCF planning requirements. HWBs should review spending on social care, funded by the NHS minimum contribution to the BCF, to ensure the minimum expectations are met, in line with the national conditions.

- **National Condition 4** – **Complying with oversight and support processes**
  Local areas and HWBs are required to engage with BCF oversight and support processes, which include:
    - a regionally led oversight process;
    - enhanced oversight where there are performance concerns.

Strategic Narrative

17. The final narrative document, attached as Appendix A, sets out Leicestershire's approach to the integration of health and social care under the national condition headings.

18. Detail within the narrative has been based on a series of partner discussions to determine priorities for delivery in the next financial year. At it's meeting of the 4th February, 2025 the Integration Executive discussed the key lines of enquiry documents produced for each line of the Better Care Fund schemes. This determined priority areas for inclusion in the plan.

19. Priority areas were determined as opportunities for further integration, areas where finances could be better aligned across partners and improvements needed to align to national priorities e.g. development of neighbourhood models of care.

20. In addition, HWB partners took part in a Joint Health and Wellbeing Strategy development session on the 'Living and Supported Well' life course. This developed the background in approach to delivery of priorities and planned alignment to the strategy refresh which will take place in 25-26.

BCF Income

21. The BCF Plan for Leicestershire for 2025-26 will total £84.4million. This includes Disabled Facilities Grant funding of £5.5 million which is in the process of being passported to District Councils. Contributions are summarised in the table below:

ICB minimum NHS contribution	£57,070,979
LA Better Care Grant	£21,824,275
Disabled Facilities Grant	£5,518,288
Total	**£84,413,542**

22. Discharge grant funding elements seen in previous years have been rolled into main funding elements for 2025-26. The Local Authority discharge grant has been incorporated into the previous Improved Better Care Grant (iBCF) and is renamed the LA Better Care Grant.

23. The overall uplift to the NHS minimum contribution is 1.7%. However, the ICB discharge grant element has been incorporated into the NHS minimum contribution and forms part of the 3.9% uplift to ASC BCF schemes that are paid for from the NHS minimum contribution. As in previous years, the uplift will contribute to additional costs associated with current schemes.

BCF Metrics

24. In addition to the national conditions, the BCF Policy Framework sets national metrics that must be included in BCF Plans in 2025-26. The local authority and ICB are required to establish ambitions associated with each metric and set out how they will be achieved. This process should then be approved by the HWBB. The framework has three headline metrics:

    - Emergency admissions to hospital for people aged 65+ per 100,000 population.
    - Average length of discharge delay for all acute adult patients, derived from a combination of:

        - proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)

- for those adult patients not discharged on DRD, average number of days from DRD to discharge.

- Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population

25. In addition to the headline metrics there are 6 supporting indicators. HWB areas may wish to use the supporting indicators to better understand the drivers of their performance against BCF objectives and specific local priorities. The supporting indicators do not need to form part of the submission:

    - Unplanned hospital admissions for chronic ambulatory care sensitive conditions.
    - Emergency hospital admissions due to falls in people over 65.
    - Patients not discharged on their discharge ready date (DRD), and discharged within 1 day, 2 to 3 days, 4 to 6 days, 7 to 13 days, 14 to 20 days, and 21 days or more.
    - Average length of delay by discharge pathway.
    - Hospital discharges to usual place of residence.
    - Outcomes from reablement services.

26. Ambitions for achieving against these metrics have been agreed across the system, involving services funded by the BCF and by non-BCF funds. Goals relating to hospital emergency admissions and discharge are aligned to ICB planning assumptions. Goals for long-term admissions to residential care homes and nursing homes have been aligned to our adult social care planning assumptions.

27. Ambitions reflect underlying changes in demand over the coming year. For example, the goals for maximum levels of emergency admissions to hospital should take into account any expected underlying growth in demand for admissions due to population demographics. This will be aligned to Urgent and Emergency Care (UEC) planning which will be based on the same increases.

Intermediate Care Capacity and Demand plans

28. HWB areas need to assess demand and capacity for intermediate care services. Intermediate care should take a therapy-led approach – with rehabilitation and reablement care overseen by a registered therapist – working in integrated ways across health and social care.

29. Building on the work in 2024-25, HWBs must therefore agree and submit a plan showing:

    - the breakdown of projected demand for both step-up and step-down pathways, and planned capacity, for intermediate care and other short-term care;
    - a narrative explanation of how these forecasts have been derived and used in wider system planning

30. Plans should cover all intermediate care and other short-term care, whether funded by the BCF or from other sources, which helps people remain independent at home

or their usual place of residence (step-up care) and support their recovery following a stay in hospital (step-down care).

31. The completed template has been included as appendix C to this report.

Background papers

Better Care Fund Planning Requirements 2025-26: https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#planning-expectations-meeting-national-conditions

Better Care Fund Policy Framework 2025-26: https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026#bcf-objectives

Circulation under the Local Issues Alert Procedure

32. None

Officer to Contact

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Lisa Carter Health and Social Care Integration Service Manager
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Email: lisa.carter@leics.gov.uk

List of Appendices

Appendix A – BCF Plan – Strategic Narrative (including appendices A-D)
Appendix B – BCF Expenditure Plan
Appendix C – BCF Quarter 3 Return

Relevant Impact Assessments

Equality and Human Rights Implications

33. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

34. An equalities and human rights impact assessment has been undertaken when the BCF was established and is provided at http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf. This identified that the BCF will have a neutral impact on equalities and human rights.

35. A review of the assessment was undertaken in March 2017.

Partnership Working and associated issues

36. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

37. Day to day oversight of delivery is via the Integration Executive, a subgroup of the Health and Wellbeing Board.

Partnership Working and associated issues

38. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the NHS Long-term plan.

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Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1
HWB	Leicestershire
ICB	Leicester, Leicestershire and Rutland ICB

Section 1: Overview of BCF Plan

This should include:

- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils):

Leicestershire County Council
Leicester, Leicestershire and Rutland ICB
University Hospitals Leicester Trust
Leicestershire Partnership Trust
Blaby District Council
Charnwood Borough Council
Harborough District Council
Hinckley and Bosworth Borough Council
Melton Borough Council
Northwest Leicestershire District Council
Oadby and Wigston Borough Council
Rutland County Council
Healthwatch
Royal Voluntary Service
Voluntary Action Leicestershire

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Stakeholders are continuously involved in BCF planning and delivery via a well-established, place-based infrastructure (see governance section below).

For the 25-26 plan development, engagement has been received from partners via a series of forums. The first took place with system partners on the 31st January, 2025 with a Joint Health and Wellbeing Development Session on the Living and Supported Well life-course of the Joint Health and Wellbeing Strategy. The second session on development was at the Integration Executive (IE) in early February, 2025 where a review of each line of spend within the BCF took place. This session also included members of the Integration Delivery and Commissioning Group (IDCG), the sub-group of the IE and members of the Health and Wellbeing Board (HWB). This was made to be as inclusive of partners as possible. The HWB, IE and IDCG membership includes local authorities (including district council representatives), Voluntary sector, NHS commissioners and providers, system clinical leads, Healthwatch and finance officers from Health and Social Care.

The review process is supported by a key line of enquiry document (KLOE) for each scheme. An example KLOE for First Contact Plus is attached as appendix A to this document. The KLOE document details value for money, return on investment, outcomes for people, staffing, contracting information and business cases along with performance and demand and capacity information where applicable. KLOE reviews occur annually to ensure that there is robust monitoring of all 89 schemes. Locally, we also review schemes in groups depending on workstreams. The workstreams are Community and Prevention, Intermediate Care and Acute Care. The division of schemes by these workstreams and associated spend can be seen in diagram 4 below.

The priorities for delivery below, include areas where partners have used the KLOE's to determine where improvements and areas of opportunity are to be made.

Health and Wellbeing Board members were involved in the shaping of the plan at their meeting of the 27th February. This meeting gave members the opportunity to comment on the schemes and spending allocations and assurance against the KLOE's. In addition the draft plan was agreed including priorities for delivery during the next 12 months. The Board meeting of the 29th May will sign-off the 25-26 BCF and accompanying templates, with the Chief Executive of Leicestershire County Council signing this off for submission on behalf of the Board using delegated powers. The governance structure for the board is shown in diagram 1, below:

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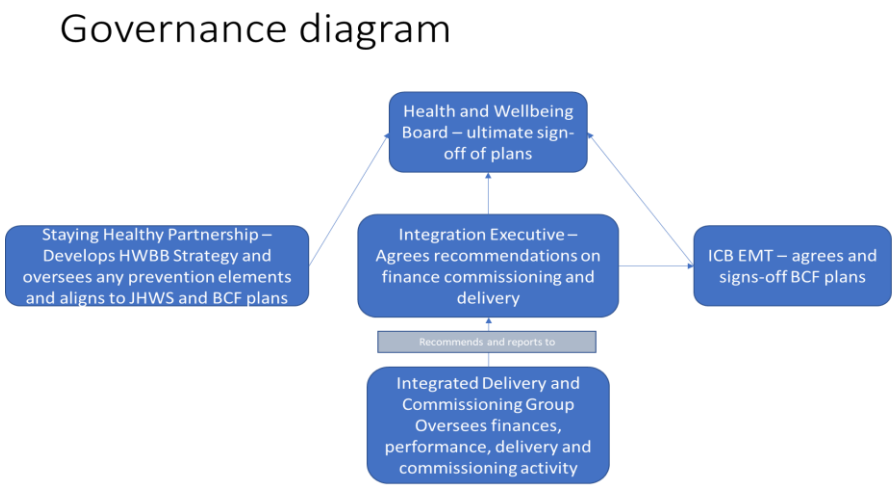
Diagram 1



The board also receives and agrees the section 75 agreement and agreement for the DFG amounts to be transported to each District Council within Leicestershire. This is passed on in its entirety with top slicing agreed by partners for wider housing related schemes.

The BCF plan forms part of the wider Joint Health and Wellbeing Strategy delivery. The BCF delivery is aligned to deliver against 'Living and Supported Well' and 'Dying Well' life courses within the strategy. Planning activity for the 25-26 BCF has again been aligned to the wider delivery of the Joint Health and Wellbeing Strategy priorities which is fully consulted on with activity agreed at group development sessions.

As in previous years there will be continuous improvement and engagement with partners and members of the governance structure to complete quarterly returns, review KLOE documentation and to ensure financial planning. The administration of this process is conducted by the local authorities Integration team who are supported by finance colleagues and commissioning support colleagues. This resource is financed through the BCF fund. This includes working with other local authority areas on their plans to ensure that this aligns to the ICB and wider system plans for integrated services across LLR. The HWB will further challenge current delivery and develop planning for future BCF years' in a workshop scheduled for Autumn 2025.

Priorities for 2025-26

The below areas of work have been highlighted as areas of priority for 2025-26. Our main priority is developing a more preventative community offer. This is where the majority of BCF investment is focused for 2025-26.

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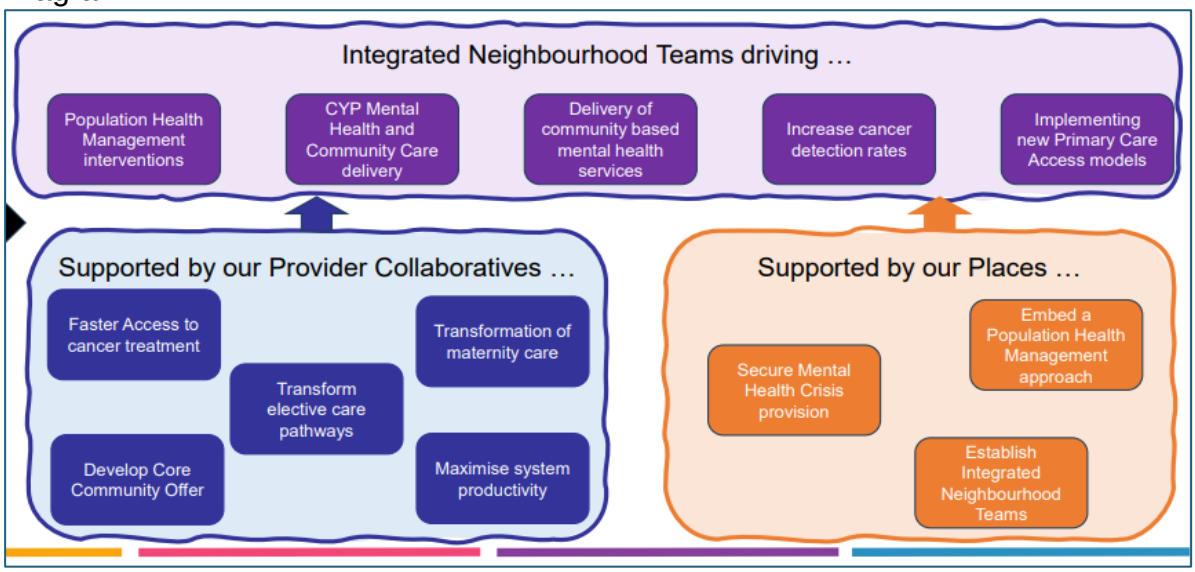
Developing the neighbourhood model of care – currently around 70% of our BCF investment is dedicated to community and prevention services (approximately 60 million pounds). Our priority for 2025-26 is to align applicable services to neighbourhood models of care in particular further development of Integrated Neighbourhood Teams (INT's) and associated Multi-Disciplinary Teams (MDT's). The initial design phase, incorporating the six core components, will look at our current service provision and how we can maximise delivery against these components by further integrating services across:

- Population health management
- Modern General Practice
- Community health services
- Neighbourhood multi-disciplinary teams
- Integrated intermediate care with a 'home first' approach
- Urgent neighbourhood services

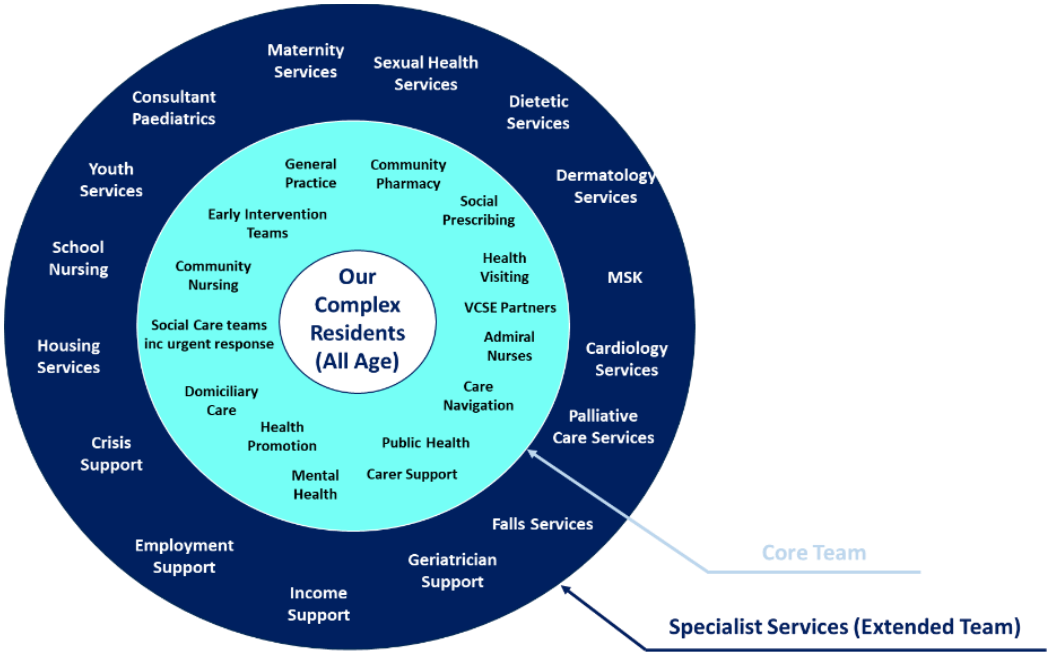
The initial design shown in diagram 2 below shows the overall services that will be incorporated into the model.

Diagram 2



The BCF programme will be supporting the place based elements in orange shown above as part of the Place based support. We have been working with other Local Authority and Health systems to look at best practice with early design examples presented to the HWB at their Living and Supported Well development session of the Joint Health and Wellbeing Strategy. One example is from Northwest London shown below (diagram 3) which represents where we would like to develop (or similar) during 2025-26:

Diagram 3



By 2026-27 as a system we are hoping to start to see outcomes from the re-design. This will include

- Improved outcomes for individuals including personalised models of care
- Improved care planning and sharing of this across all partners
- Better access to community services with fewer attendances and admissions to acute care (see below metrics section)
- Fewer admissions to long-term care (see below metrics section)
- Increased use of proactive care models utilising population health management data across services

Risk stratified population health management data will drive the demand of developing MDT's, which will focus on delivering support to cohorts 9, 10 and 11 on the below slide. Locally, this equates to 82,207 people in Leicestershire alone. MDT's will need to be made up of a combination of clinical and non-clinical staff from across the NHS and social care utilising data from the existing care co-ordination proactive care model as a proxy for demand and capacity modelling. Diagram 4 shows the population health management cohorts and how the MDT's align. INT's already focus on delivering support to people in the lower cohorts, however the aim is to streamline this more effectively in the next 12 months.

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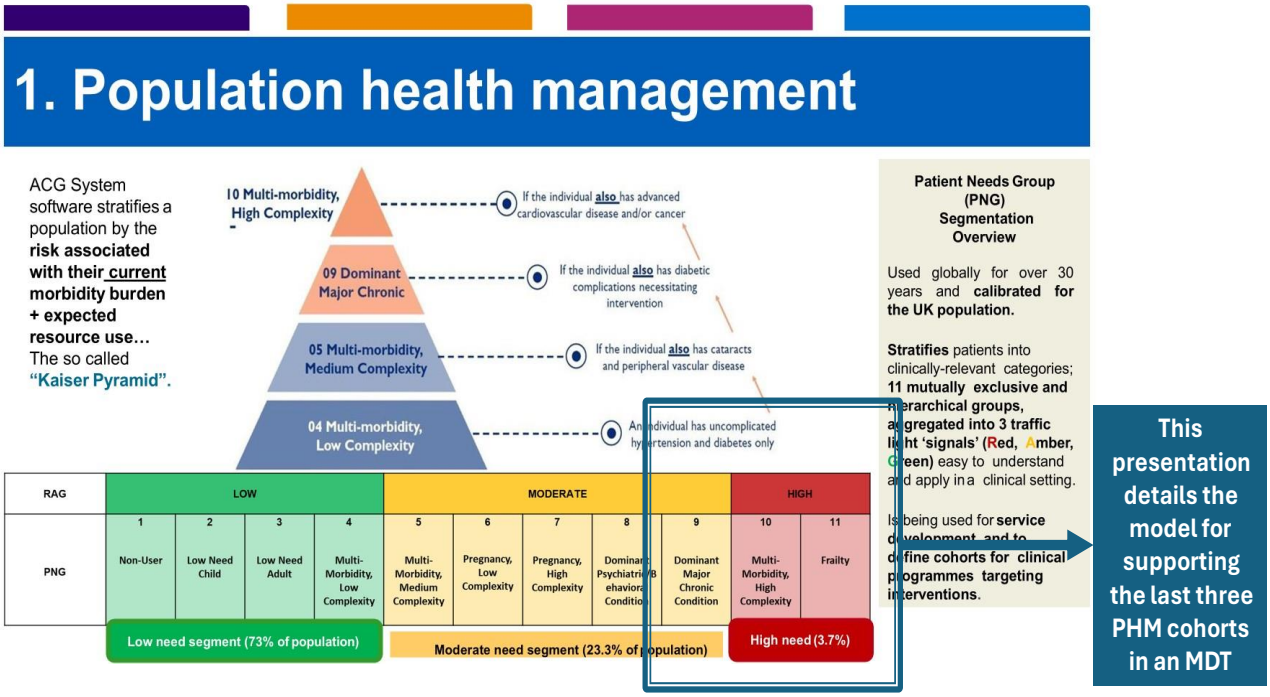
Diagram 4

How does this fit with the work so far?



Linked to delivery of the above emerging neighbourhood models, are a number of supporting priorities for 2025-26 which we will review in order to ensure our schemes are fit for purpose and offer value for money with the desired outcomes.

- **Review of prevention services** - the County Council is conducting a review of prevention services. The aim of this project is to review prevention activity across the council to ensure we are doing our best to identify and meet need early, reducing the need for specialist services wherever possible. Over the last 18 months, information has been collected from teams across the council to give a clear picture of the council's prevention offer and the cost of prevention services. This has involved mapping functions and activities, areas of spend and funding sources, statutory requirements and performance where available. We are now moving into the next phase of the review, with the support of an external partner, help us with this complex, cross-cutting review of prevention services. Between February and May 2025, they will be working directly with teams to understand more about our service areas: They will be building their assessment based on a review of key reports, financial and performance information, interviews, case reviews and workshops. Once an in-depth review has been completed, we will be co-designing next steps and testing ideas with teams during the summer.

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- **Assistive and digital technology and equipment** – BCF investment in this area will be approximately 1.5 million in 2025-26. Currently, elements of AT and equipment are delivered across a range of organisations and to support a range of services often inconsistently available. During 2025-26 we aim to re-design and progress delivery of this across health, housing and LA's to provide more effective and efficient services. This will begin as soon as the plan is approved and is expected to take the full financial year. This will increase availability for residents to digital and technology services and increase capacity for delivery. To support this, within ASC we are reviewing our AT service, Just Checking. This is an activity monitoring system that helps care professionals complete objective, evidence-based care needs assessments of adults with dementia, learning disabilities, autism, and other complex conditions. This supports a number of indicators and outcomes and helps to right-size care packages via a review and upgrading equipment. Within this we have also looked at early outcomes from areas of best practice (Manchester) where a 22% reduction in annual care costs for users of this technology were seen compared to the control group.

- **Home visiting service / night nursing service** – these are both contracted services so will be reviewed as part of contractual arrangements to maximise benefits to residents with any improvements to services to take effect prior to Winter 2025 with further re-procurement opportunities being sought in line with the end of the current contract. This will be measured by increased coverage and number of recipients supported.

- **Creating a Single Point of Access** (SPoA) – work has begun on this programme in the 4th quarter of 24-25 and will continue throughout 25-26. A maturity matrix against the NHSE framework has been completed for LLR. Our system aims to have a single point where community requests for support are triaged and correctly managed in the community across a range of co-ordinated services. The aim is to reduce 'ping-ponging' residents between services (including GP's, Urgent Treatment Centres, 111 and EMAS) and to better advise them of support available according to their needs via a single telephony service. This will build on the learning from the Unscheduled Care Coordination hub and involve all partners in delivery of community health and care resources.

In addition to the above priorities, members of the BCF governance structure have highlighted additional areas where review of integration opportunities will be investigated during 2025-26. This list was compiled using the KLOE documentation review which is completed annually as part of BCF planning:

- **Review of the role of trusted assessors for care homes** – currently there are two models of delivery in LLR – we will aim to look at whether there is merit in re-designing these services. This will be completed by winter 2025. Currently acute trusts still face delays with care homes assessment timescales. This will reduce the LOS past expected discharge dates. The contract currently in place is up until Mar 26

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so alignment planning will be completed along with and commissioning requirement timescales by this stage. For winter 25-26, support to P0 patients returning to their own home where this is a care home will be provided to support speed in decision making for returns.

- **Quality in care homes** – looking at opportunities to work closer with ICB quality teams. This will begin at plan approval stage and is expected to take 6 months for the initial phase of development.

- **Integrated stroke services** – this needs to be reviewed with a view to reducing waits across LLR for community based services and hope to increase capacity. Currently LPT and UHL led contracts. This has begun in very early stages of development and is expected to take the full financial year. Current contracts are in place until end Mar 26.

- **Primary Care Co-ordinator** – this needs to be reviewed with regards to other ED services and wider work on points of access and step-up work. This will be aligned to UEC models of delivery which are currently in draft form. Timescales will be dependent on wider work to improve non-admission services including the development of the Frailty SDEC which aims to further reduce emergency admissions. This work will aim to be complete within the first two quarters to be in place for winter 25-26.

- **ICB will be reviewing the CHC framework practices** and any associated contracts – this could include wider development of working relationships in practice between health and social care. This began in quarter 4 of 24-25 and with some elements of the review due for completion in April 2025 with other elements dues to complete by June 2025

Key changes from the previous plan

There are several key changes to the previous BCF plan. These are listed below:

- In 24-25 the governance process for HWB and BCF planning and agreement changed as Integration Executive sub-groups were reduced. This has reduced from two sub-groups to one in order to ensure join up of commissioning and delivery intentions for integrated schemes

- Increased focus on step-up, transforming neighbourhood services, which is linked to delivery of intermediate care delivery and urgent and emergency care diversion to reduce demand

- Review of falls services in order to support more people across Leicestershire and reduce admissions from peoples own homes. This began in 24-25 with a view to completing any commissioning to support the consolidation and re-design by the end of the 25-26 financial year. This year, FaME (the Falls Management Exercise

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programme) has been included in the BCF. This is an evidence-based, strength and balance exercise programme that has been shown to reduce the rate of falls by up to 26%. It is a structured 24- week group-based programme (with additional home exercises) delivered in community venues and aimed at people over 65 who are at risk of falling (have fallen in the previous year or have a fear of falling). Class sizes are around 10-14 people and are delivered by specialist postural stability instructors. Steady Steps is the name of our LLR FaME programme. Public Health England have estimated that FaME has a social return on investment of £2.28 for every £1 invested, including savings for health and social care. The programme is managed by Active Together using local delivery partners across LLR and supports the BCF indicator to reduce emergency hospital admissions due to falls in people aged 65+. In 23/24 there were 43, 24-week courses run across Leicestershire and Rutland attended by 465 people at a cost of £331 per person (£13.80 per week). In 25/26 we hope to create efficiency by reducing this unit cost to £298 per person (£12.41 per week) by increasing the number of participants to 516 people. The scheme is cost effective as evidence shows that the rate of falls for every patient who has completed the programme could reduce by up to 26% in the subsequent 12 months.

- Discharge to Assess bedded models to be commissioned to reduce need for temporary care placements. The first cohort of beds is due to come online to meet a proportion of the demand in July 2025 with additional capacity increasing through the rest of the financial year.

- Increased focus on equality and diversity considerations in specific service redesign. This has been focused on P1 intermediate care during 24-25 and will be expanded to other schemes during 25-26

- Focus on proactive and neighbourhood care models and further utilising population health management data and risk stratification to focus care on the greatest need. This will increase responsiveness and avoiding acute care needs. This is linked to urgent and emergency care, focuses on frailty support and production of a single point of access.

Aligning the plan to improving flow in Urgent and Emergency Care

Within LLR, Urgent and Emergency Care (UEC) governance is under review and transformation. This includes system-wide agreed priorities. These are currently in draft form, however, early work to align lace-based BCF plans has taken place to ensure it supports out of hospital services to reduce demands on acute care and to improve discharge. Initial priorities have been subject to further work across system partners through a variety of workshops. These have been listed below in their current format with BCF scheme activity to support each one, however the priorities are subject to change prior to the commencement of the next financial year:

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UEC plan priority	Leics BCF schemes that support
Prevention and proactive personalised care (including LTC management) is embedded across the system	ASC review of prevention services / Care Co-ordination model works on proactive care and utilises risk stratified GP data to identify people who may need support when likely to be an acute admission in the next 12 months
When people need same day or urgent care, they can easily and rapidly access the right care at the right place at the right time	Aligning single point of access models. HART Urgents service (previously Crisis Response) into an LLR model with health and other community partners
Effective and efficient emergency care pathways that are appropriate, safe, and integrated	Reablement services working on non-admission wards alongside therapy teams / Review of falls admission avoidance cars / Urgent Treatment Centre review
Effective and efficient emergency care pathways for children and young people, mental health crisis response, frailty and end-of-life care	Housing Enablement Team working across Mental Health wards / Re-investing in the Mental Health Relationship Officer / Review of End of Life care strategy due for completion in 25-26.
Partners work together to ensure joined up and coordinated care, including improved flow and early supported and safe step-down from services	Intermediate Care P2 offer to be commissioned and to begin in 25-26 to cover the gap in the D2A offer for P2 group of patients / Continuation of the scheme to provide temporary support to capacity rejections from the reablement service and investment to increase the capacity to meet demand.
Be data and intelligence led; fully understand and predict our population needs in order to support those at greatest risk, tackle health inequalities and deliver tailored population-based approaches	Utilise population health management data to shape a range of neighbourhood models of care schemes / Utilise new equalities framework when developing schemes

A brief description of the priorities for developing intermediate care (and other short-term care).

LLR has had a plan to improve and deliver integrated Intermediate Care Services since 2023. In 25-26, Intermediate Care (IC) will prioritise recruitment to ensure we meet the increased demand for Pathway 1 Intake Model and a shift towards step-up care. Renewed investment within the plan supports this from NHS minimum contributions and the Better Care Grant. Ongoing risks to recruitment and retention pose as a challenge, however, we will seek to regularly review our recruitment processes and look at streamlining teams and activity across Leicestershire for better effective service delivery. The plan is split into three parts with an accompanying programme plan. The three parts and developments for 25-26 are listed below alongside additional workstream on equality and equity of access:

- Pathway 0 support from the voluntary sector (RVS) will continue in 25-26 supporting approximately 700 people annually along with care co-ordinators working with approx. 2500 people leaving hospital each year on this pathway. UHL Urgent and Emergency Care discharge working group will be working on achieving a target of 66% P0

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patients leaving on their discharge ready date. The targets in this plan align to the activity in the UEC Discharge Working Group in order to achieve ambitions.

- Pathway 1 – IC at home - We will endeavour to stabilise our P1 intake model already established by increasing and maintaining workforce to meet demand. This is supported with a further 883k of investment to ensure demand is met and people are able to return home whilst this expansion in service continues. During 24-25 demand for reablement services increased by 30%. Overall, our commitment to Home First will continue. During 24-25, 6% more people were supported into care at home than in the previous year (reducing demand for P2 bedded care). Our investment in reablement and review teams ensure this is right sized to meet need with the average cost of a package reducing to £343.42 from £356.57 at the start of the year. Furthermore, the average hours have reduced to 14.07 from 14.36 at the start of the year. Our priority will be to continue to support more people at home with the right-sized package to meet their needs with more people accessing reablement to increase the likelihood of independence. We will further align community step-up services to expand the IC model and meet the demand using continued service expansion and finance modelling ensuring the pathway is rightsized.

- Pathway 2 - Within our pathway 2 work stream we will continue to prioritise our demand work for modelling step up and implementing an agreed option from our long term P2 proposal paper to meet the current bed gap for discharge into a 3 R model bed for every person assessed as needing this level of support. Proposals were based on continuous demand and capacity modelling to establish the overall needs in relation to bedded D2A care. This included ensuring that the needs of this cohort could not be met at home. In addition, we will look to transform our High Dependency, Bariatric and Nursing cohorts and ensure patients receive the right care, at the right time in the right place, again using demand and capacity modelling and effectively reviewing and reporting on impacts of lengths of stay. Several risks are posed around funding for each cohort and inequality due to bed deficit that will regularly review and monitor within a multi partner steering group. Over 24-25 the use of short-term bedded care has reduced by 5% with discharge P2 usage reducing by 6% on the previous year. Our demand modelling has shown that we need a further 88 beds across LLR (50 for Leics) to support reablement, rehabilitation and recovery. Over the last 2 years Intermediate Care has worked to reduce P2 bed usage by over 35% so we are now confident that this is the cohort of numbers that remains requiring P2 support due to analyses for the P2 demand paper (attached as an appendix B). This shows analysis of demand at sub-pathway level to confirm requirements of this cohort. Delivery will be supported by investment in the P2 IC model of approx. 1.5 million with phased additional beds commissioned throughout 2025-26. By the end of 2026, it is projected that there will be a need for only 18 short-term spot-purchased beds required to meet demand for Leicestershire residents. Over winter, to reduce the risks associated with increased demand, plans to maintain the use of a further ward in Leicestershire Partnership Trust community hospitals (Grace Dieu) will alleviate

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demand for this cohort as an interim solution. Increased solutions for step-up intermediate care are also being evaluated including increased therapy support at the front-door to support triage into step-up beds in the community where an acute bed is not appropriate. This will begin working with the frailty SDEC cohorts.

- Decision making - Aligned to the above, a Voice of the Person survey will be evaluated and used to inform patient outcomes and how we can improve our services by providing crucial insights to what is working well and what isn't. This will allow us to deliver better tailored services and develop our personalised models of care.

- Equality and equity - An overall priority for 25/26 will be to review the quality and equity of access for all LLR residents for Intermediate Care and to implement any recommendations through our Equality Delivery System Task Force with leads across the system. This has begun within P1 services and will expand during 25-26. They will gather comprehensive and diverse feedback to ensure any gaps are captured and resolutions are embedded to eliminate risks or inequalities to those from protected characteristics. They will develop a Framework to provide service overview to enable us to remove any risks or barriers service users may face in accessing services, which will also support frequent evaluations and determine any risks/gaps that can be rectified as soon as possible. Reporting findings will be developed from engagement events alongside The Intermediate Care Steering Group and EDI improvement plans.

The current domiciliary care contract will be re-tendered during 26-27 this will further maximise delivery of support for care at home. This will be right-sized and developed with the Homecare Alliance in order to include providers in the shaping of future services. This will be in the planning stage during 25-26. BCF investment of circa 15 million supports delivery of this. Within Leicestershire there are no waits for domiciliary care pick-up by providers for step-up or step-down provision.

Other areas of short-term care will form part of the neighbourhood model of care. This includes use of the voluntary sector alongside formal care provision in order to maintain independence at home. Examples include, the Royal Voluntary Service discharge support, support to carers, dementia service contract led by AgeUK and Local Area Co-ordination and First contact plus which connects people with support in their local community. This connectivity builds on the integrated reablement and therapy services in localities where once a week their MDT meeting links to other locality support services.

Brief challenges, risks, mitigations and timescales

There are challenges that have been identified in delivery of the BCF plan for 25-26. This includes ensuring capacity is in the right place to support needs. For example, the focus for delivery has been on improving discharge timescales and this has been at the detriment to reducing flow into acute care services which has seen an 11% increase during the past 12 months. This shift is a system approach to improving community services to support reduced reliance on emergency care which will take time to embed. This may be beyond the

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timescales for the next 12 months and may have difficulty in seeing reduced demand within this time period. However, schemes will have a focus on community and step-up care built into them to ensure that they link to the left-shift required. This will be supported by robust demand and capacity modelling and monitoring to show impact.

As a system we recognise that we haven't quite got personalised care right for individuals including conversations around care provision with partners and carers and family members. To mitigate we are ensuring that we work more closely with co-production groups and care providers to develop services and to renew work within intermediate care programme on the voice of the person.

We are keen to work with NHSE and the BCF national team on support for key priorities. Initial support may be needed to help with joined up conversations around the national CHC framework and how this can better improve relationships. Support from other systems on provision of step-up bedded care would also be useful to include in the next phase of the delivery of our intermediate care model along with supporting any national recruitment drives. However, recently announced changes to NHSE and ICB's (in an already lean system) could severely impact not only the support required but also on delivery of some of the key elements of this plan.

Timescales for delivery of schemes and impact vary depending on maturity of the plans. Impact on metrics will be expected within 25-26 on the Intermediate Care P2 D2A offer. This will have immediate impact on reducing timescales for discharging patients (over and above the current capacity) into residential care settings but overall this will only have an impact of 0.5% on discharge timescales overall. Regardless, this financial year should see capacity increased in P2 D2A by 88 beds. For this cohort, delays in discharges should improve by reducing delayed bed days by approximately 700 per month and will provide equitable access to a recovery, reablement and rehabilitation offer to all. This has been reflected in the revised demand and capacity modelling.

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Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money

The LLR system is currently aligning schemes to deliver proactive care models into a Neighbourhood Model of Care. This will support the shift from sickness to prevention and will add to the models already in place to ensure there is an integrated offer for residents. For example, our current care co-ordination teams which are based in each locality hub, proactively identify and manage caseloads in excess of 200 per month across 16 FTE staffing (in addition to approx. 200 pathway 0 patient support per month). These are identified from risk-stratified population health management data extracted directly from GP systems.

Plans for 25-26 include learning from the models in place and aligning other community support teams to provide similar services including social prescribers and Local Area Co-ordinators. This will be supported by reablement, therapy and nursing teams which already deliver services on the same locality footprints. Levels of case management resources will be modelled on demand for current services and using population health management data to increase preventative caseloads to enable the shift from sickness to prevention.

Nationally, LLR has taken part in a series of peer reviews with other regions and NHSE. This has enabled us to connect with other systems for learning on discharge pathways and intermediate care models both to share our good practice and to learn from other areas. We plan to work alongside areas such as our step-up community bed offer as part of our Intermediate Care Programme.

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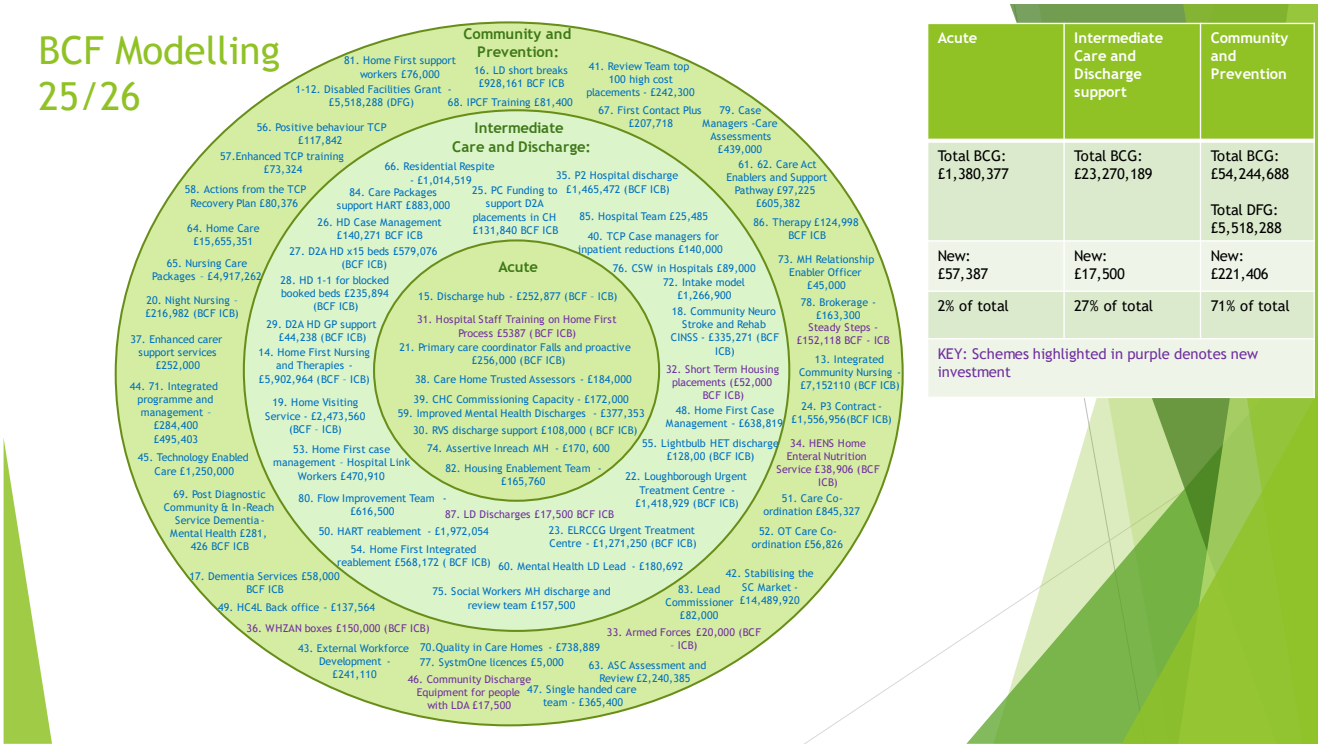
Our BCF plans have been aligned to this model when taking decisions around funding and value for money in delivery of community care services. Areas for more integrated work is detailed above and investment has been aligned to follow this.

The below diagram 5, shows the level of investment aligned to community and prevention activity in Leicestershire. For 25-26 this is 71% of the overall fund with 27% aligned to Intermediate Care and 2% aligned to acute care.

Diagram 5



Acute	Intermediate Care and Discharge support	Community and Prevention
Total BCG: £1,380,377	Total BCG: £23,270,189	Total BCG: £54,244,688 Total DFG: £5,518,288
New: £57,387	New: £17,500	New: £221,406
2% of total	27% of total	71% of total
KEY: Schemes highlighted in purple denotes new investment		

Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans

Below is a table that shows the metrics for 25-26 and associated targets with explanatory notes on the ambitions:

Metric	Ambition	Comments
Emergency admissions to hospital for people aged over 65 per 100,000 population	2550 admissions per month	The ambition for 25/26 is for projected monthly targets to be lower than 24/25 actuals with a target to improve on 23-24 rates of admissions. This represents a reduction of 2% on 24-25 admissions and a reduction of a further 0.8% on 23-24 rates. This equates to a reduction of approx. 70 admittances per month. Our frailty SDEC which began in Jan 2025 has initially seen a 76% admission avoidance rate – this will contribute to 31 of the 70 required avoidable admissions for Leics (based on 71% of demand) and plans to extend this function aim to lead to a potential further 30

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		avoidable admissions per month. Reduced admissions due to falls will contribute to the remainder of the target. This has reduced by 6% in 24-25 and the aim is to reduce this again by a further 6% which equates to 9 emergency admissions per month. The remainder is supported by increases in activity in Virtual Wards. This will equate to approx. 14 more people supported for step-up virtual care in Leics.
Average length of discharge delay for all acute adult patients, derived from a combination of: • proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) • for those adult patients not discharged on their DRD, average number of days from the DRD to discharge	89%	Current data shows performance at approx. 85%. The target of 89% is in line with the Criteria to reside target for 25-26 across acute care partners. Achievement of this will be graduated from the current levels to reach 89% by Mar 26. Our current system activity in support of this is listed below. This is in line with UHL planning: •Develop/refine nervecentre collection of 'Criteria to Reside' to aid data accuracy •Produce a SOP on Criteria to reside/ EDD/ Planned date of Discharge. •Undertake staff education / training •Continue to develop Criteria Led Discharge Pathways. •Continue to work with CMG's to reduce internal reasons for incomplete discharges •Staff education and training / communications on Estimated Discharge Setting Two voluntary organisations provide support to P0 discharges will receive investment to work towards meeting this target during 25-26 P2 D2A bed offer for which for Leics will see a reduction in days of 190 bed days per month across 32 patients. The numbers of people is a reduction in 5% from the current data of 628. The number of bed days represents a reduction in 8.5% of lost bed days. Other activity in support of this includes, increase in HART capacity, maintaining current investment in HART capacity rejection care packages. This demand is derived from demand and capacity planning. Will maintain P1 discharges at approx. 2 days for County.
Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population	867	Target of 23-24 as this was the last full year of data linked to latest population estimations. Reduction in long-term bedded care across Leics has been seen in prev years. Our target is to get back to the 23/24 level (867). Divide by four quarters is 216/217 per quarter or on average 72 admissions per month. The current figures for admissions per month is approx. 75 based on full year 24-25 projections.

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Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care

Leicestershire has been improving against targets for 'home first' as part of the wider Adult Social Care strategy for service delivery. This has resulted in a reduction in demand and usage for bedded care of approximately 35%. During the focus on care at home, reablement demand has also increased by approx. 75% with capacity increasing by 38%. This has reduced the amount of long-term bedded care need also along with a successfully commissioned and healthy domiciliary care market. Which supports unmet demand in reablement services and also increases flow through hospitals by providing timely discharges and exit from reablement services.

In addition to the above the plan for 25-26 will build on the integrated therapy and HART reablement offer in localities which has reduced waiting times for elements of the service such as equipment ordering and delivery, increasing capacity and building better relationships between services. This will be expanded to include additional tasks around skin degradation and work with stroke services to reduce wait times. This will be part of the intermediate care model and also build on the emerging neighbourhood model of care.

The following schemes and areas of work for 25-26 to support this are listed below:

- Falls commissioned service review – to provide support to fallers at home to avoid conveyance and ensure people are supported to remain at home. It is projected that this will increase to include an additional 28 people per month for Leicestershire by quarter 3, 2025.
- Increased capacity in review services to ensure that care is right-sized to meet needs. This will continue the reductions in domiciliary care packages in hours and costs seen in 25-26 (see data in IC Pathway 1 section above)
- Review of front-door services to avoid admissions and to provide a same-day service in a SPoA – detailed above
- Development of neighbourhood models of care shifting focus to prevention (also detailed above)

Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

The consolidated local authority discharge fund will continue to support with the same activity as last year for discharge. In addition, the fund will support the following schemes:

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- Increase usage and ordering of care technology – this has shown to improve the amount of people remaining at home post-acute spell in hospital. Outcomes should see an improvement in the number of people accessing long-term care homes.
- Increased support to the intake model to enable step-up pathway one offer – see information in IC section above
- Additional home first team support workers – see outcomes and timeframes associated with increased P1 care at home above.
- Home Care Packages due to HART no capacity – see IC section on meeting demand for reablement services through use of care packages and increased review teams to support 2 weeks post discharge
- Lead Commissioner Post
- HET Expansion – In 24-25 expansion of the overall HET service was funded through the discharge grant. Planning and evaluation report of this expansion is attached as appendix C. This will continue in 25-26 and includes an increase in funding to allow the service to rent 5 serviced units to support people with short-term needs whilst finding permanent accommodation. This will be subject to a PDSA review within the first 6 months of 25-26.

Across Mental Health a range of support services are included in the usage of the grant for 25-26 investment:

- Agency Social Workers (MH teams)
- Community Support Workers in Hospital Team (MH)
- Mental Health Discharge Unit has been built with Leicestershire Partnership trust for Local Authority Mental Health staff to be able to access patient information to build on Integration between Health and Social Care. We are currently onboarding staff members to have access to this custom built discharge unit and we aim to have this completed by June 2025. This will allow sharing of appropriate information which will facilitate quicker and safer discharges. In addition some of the benefits will also include:
    - AMHP assessments contributing to analysing risk and current services/circles of support
    - Reduce duplication of information gathering from patients between social care and ward staff
    - Staff will be informed on the person they are visiting before they enter the ward.
    - Quicker preparation for tribunals

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- Timely social care assessments and interventions
- Reducing the risk of breeching legal time frames for tribunals
- Help put provisions in place before visit i.e. housing, adaptations, support reducing risk of re admission and reducing the length of stay
- Reduces miss communication from different ward staff and social care staff

- Mental Health Relationship Enabler - significant delays were identified in the discharge of homeless mental health patients from hospitals, who had previously come from a county setting prior to discharge. County settings involve multiple district councils, creating complexities that disadvantage patients requiring discharge. These administrative and procedural differences often result in extended hospital stays and an increased risk of readmission due to inadequate post-discharge support. To address these challenges, a pilot scheme was introduced to streamline the discharge process, enhance inter-agency collaboration, and provide structured post-discharge support to reduce the likelihood of readmission. The initiative involved creating a dedicated role within the Housing Enablement Team (HET) to specifically assist district councils in managing complex mental health discharge cases, ensuring smoother transitions into appropriate accommodation and long-term stability. The Mental Health Relationship Enabler role was established to bridge the gap between mental health services and housing, working closely with district councils and the Bradgate Mental Health Unit (BMHU) to facilitate the timely and effective transition of homeless patients into suitable housing arrangements. The core objectives of this role include:
  - Reducing Delayed Transfers of Care (DTOC) for mental health patients with housing needs.
  - Providing intensive post-discharge support to reduce readmissions.
  - Facilitating better coordination between hospital discharge teams, local authorities, and housing providers.
  - Addressing barriers in the housing allocation process to ensure vulnerable patients receive appropriate accommodation.
  - Impact and Future Plans (2025/2026)

  The pilot has demonstrated a reduction in county-based delayed cases due to the targeted intervention model. The inclusion of structured post-discharge support has proven essential in reinforcing confidence among partner agencies and improving patient outcomes during the critical transition period. The officer supports approximately 70 people annually. The scheme has led to:

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- A reduction in hospital readmissions for patients with housing-related discharge barriers.
- More efficient hospital discharge processes, alleviating bed pressures and improving patient flow.
- Stronger inter-agency collaboration, fostering better relationships between NHS services, local authorities, and housing providers

- Improving Mental Health Discharge supports a variety of staffing roles to contribute to improving discharge for Metal Health:
  - Hospital Discharge team. This team supports people who need commissioned
  - support out of hospital that is based at the Bradgate unit (Care act and S117.)
  - Community based service - Duty of assessing people who need compulsory admission to hospital. This is a working age adults service.
  - Forensic team- discharge through forensic route (more secure setting). This is also a working age adults service.

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

How 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)

Analysis of 24-25 data on HART reablement demand shows a projected increase over the course of the 12 months by approximately 30%. There is a projected stable amount of demand from hospitals (this is expected due to a finite number of beds). This increase has been factored into the demand modelling. The service has increased capacity over the past 12 months by approximately 10%, however this is not keeping up with increases in demand. Further investment has been apportioned to ensure continuous recruitment into the service. This has been ongoing throughout 24-25.

To mitigate, we will meet the unmet demand with domiciliary care packages as an interim, with a daily review of capacity. This ensures that there are no delays to discharges and residents can access the reablement service as and when capacity becomes available in the community. In cases where this does not occur, our two-week review team support the

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person to right-size their care at this point. This investment into additional care packages will continue in 25-26 to support hospital discharges, paid for from the Better Care Grant. It is hoped that as recruitment continues to increase the need for temporary packages will decrease as more reablement capacity becomes available.

During 24-25, led by Leicestershire County Council, the Intermediate Care Steering Group employed specific resource to conduct an options paper on the requirements for pathway 2 discharge to assess bedded care requirements. This is intended to form the basis of the long-term commissioning plan for future requirements and is being used to inform demand and capacity requirements for future years. The piece of work identified an 88 bed gap for the LLR system which new models of care will attempt to fill during 25-26. Currently this cohort is supported by temporary residential care placements but do not have comprehensive access to therapy and reablement services.

Three options from the paper will be worked on in more detail. This includes purchasing system run beds for D2A patients, increasing community capacity for low-level medical step-down requirements and increased utilisation of community hospital capacity (which has already been met in part during 24-25).

To mitigate further the needs of the cohort, additional beds have been utilised through periods of surge including winter with 20 beds in a further community hospital ward flexed to increase capacity. In addition, investment from the discharge grant has enabled the system to support people for the first 4 weeks of their bedded stay to receive onwards assessment and support. This enables an equitable financial provision for all in the first 4 weeks post discharge. Investment will continue in this way but has been scaled down in-line with proposed additional capacity beginning.

How capacity plans take into account therapy capacity for rehabilitation and reablement interventions

For therapy capacity, this has been aligned to all models of intermediate care within LLR. Commissioned therapy teams support the High Dependency cohort and bariatric cohorts within specifically commissioned bedded contracts. In addition, therapy capacity supports intermediate bedded care on specific wards in community hospitals. In total this equates to 36 beds. Therapy will be aligned to the additional 88 bed gap detailed above.

Within localities, therapy and HART teams have become integrated to ensure maximum coverage to care needs across Leicestershire. This has enabled HART to increase capacity in part through trusted assessment across teams and daily MDT's between reablement staff and therapy staff in order to co-ordinate care needs for individuals. Therapy capacity has increased by 15% during 24-25 and this has been reflected in the demand and capacity plans for 25-26.

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Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

Under Section 14Z45 of the Health and Social Care Act 2022 and as set out in the NHS Constitution we have a duty to involve the public in our commissioning plans and decisions that we make as a commissioning organisation. LLR ICB has a clear vision for engagement and patient experience. We want our patients, carers public and stakeholders to be among the most involved, informed and empowered when it comes to local healthcare. We recognise the fundamental importance and benefit of ensuring that our decisions are shaped through effective communication and engagement with the local population.

Principles for working with people and communities
The principles that underpin our work with people and communities align with 10 national principles for how ICSs should collaborate with people and communities, are shown below:

- Build on the engagement capability and capacity in our workforce and empower our 21,000 members of staff as the NHS or social care family, service users/patients, community members and carers, to make connections to social change.
- Embed business intelligence and insights from people and communities into the heart of the ICS, ensuring that at all levels of decision making and implementation they are a valued asset, used to improve experiences and enhance the health and wellbeing of our population.
- Harness the power of Equality Impact Assessments to support the eradication of health inequalities. To help embed equality considerations (including health inequalities) within decision-making, we will use the six steps approach of the LLR Inclusive Decision - Making Framework.
- Build relationships with children, young people, families and groups that represent them

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- Build stronger relationships with unpaid family carers and groups that represent them ensuring that they can share their experiences of care and drive improvements across health and care.

Our work with the public and communities discharges our public involvement duty, as set out in the NHS constitution. It also takes account of the range of legislation, including the NHS Act 2006, that relates to involvement and decision making.

We have placed the voice and experience of people and communities in LLR at the heart of the work of the ICB and partners and as a golden thread through the governance structure (see structure below). This is supporting the system and all partners to understand what people need, what is working, what can be improved and how we can work together to deliver what matters to the people we serve. Evidenced based insights and business intelligence, based on the experiences of people into the delivery of safe, high quality and compassionate care is reported into the ICB board through the Quality and Safety Committee, which assures that the data is being acted upon.

The Public Sector Specific duties also require the ICB to publish equality information annually that sufficiently demonstrates how we are thinking about equality across the services we provide and/or commission and our employment of staff. Our EDI Annual Report demonstrates how we meet these duties see link:

https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/

The report includes the requirement to produce specific and measurable equality objectives and publish our Gender Pay Gap (this is also found separately on the website).We also demonstrate due regard to advancing equality and reducing inequalities through our Equality Impact Assessments which are listed in the Annual Report and some good practice assessments are found on the on the website. We are presently taking the EDI Annual Report for 2024/25 through our governance procedures. This includes more information on the Armed Forces Act 2021 (AFC).

More specifically, in response to in NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006), the ICB has developed its first annual report on health inequalities. This is the first time the ICB has compiled this level of health inequalities for the system – covering 10 clinical domains with a range of indicators segmented by deprivation and ethnicity. The data gives the system a comprehensive baseline assessment of inequalities in access to services that are driving inequalities in patient outcomes and patient experience.

- Core population demographics for LLR with a focus on the drivers of health inequalities
- Health inequalities in LLR
- A review of how LLR is addressing health inequalities strategically
- A review of the work that LLR, LPT and UHL are doing to address health inequalities

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- LLRs statement on information on health inequalities across 10 domains, setting out a summary of the key metrics, local actions that are in place to target and address health inequalities and case studies of key actions that the system is taking.

This report has been developed in collaboration with LPT and UHL and features a wide range of case studies from across the system illustrating the breadth and depth of initiatives that are targeted towards reducing health inequalities and improving health equity.

This is the first time that this breadth and depth of health inequalities data has been made available to clinical and system leaders to support and drive change. It is essential that the system acts on this evidence to address health inequalities and improve outcomes for the most disadvantaged populations in the LLR system.

This report provides the system with a baseline for health outcomes and for access to services from a health inequalities lens. There is ongoing work, through the delivery partnership and clinical executive to raise awareness of this report and the key metrics that are included with the aim that these groups endorse the health inequalities dataset as the single, unified dataset to drive transformative improvements across all workstreams, ensuring a consistent and evidence-based approach to addressing disparities. It is important to note that the report does not include all the programmes of work the ICB is involved in with respect to health equity but provides examples of ongoing work.

The report has been approved and will be published on the website in accessible format in due course.

Our focus in 2024-25 was to work with BCF partners to improve access to care and experience of care for in the CORE20 and PLUS groups – linking to opportunities created through the primary care enhanced services and the developments outlined in the Fuller Stock Take - particularly in primary and secondary prevention.

During 24-25 Leicestershire County Council, ICB and provider resource was aligned to reviewing integrated care against national and equality diversity frameworks. An initial strategy for this was developed and work began on evaluating equality within Intermediate Care provision.

This began with a partnership review of Pathway 1 intermediate care against the NHS Equality Delivery System (EDS) Domain 1. EDS is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010 and domain 1 covers commissioned or provided services. The LLR team conducted a series of workshops with service users and workforce in order to grade ourselves on equality and diversity characteristics when delivering core services. The latest copy of the draft report is attached as appendix D. The outcome of this work will be an improvement plan which is drafted and set for approval in April 2025.

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During 25-26 a timetable for conducting similar equality and diversity analysis against our key priority areas for delivery will be developed aligned to highlighted areas for progress listed above.

We continue to invest in services that aim to specifically reduce health inequalities particularly using population health management data in the following invested schemes:

- Care Co-ordinators – Strengths-based support to a predominantly older group of people and those with multiple long-term conditions and disabilities to access care and support – including community assets.
- Specialist support for those with Hoarding Disorder – DFG top-slicing
- Housing Enablement Team (HET) – provides expert housing support to facilitate hospital discharge (including in the range of MH facilities) for a cohort of people with hard-to-resolve housing issues – homelessness, insecurely housed, No Recourse to Public Funds, in dispute with landlord etc.
- Carers support payments – to help identify and support unpaid carers
- Dementia specific support
- Transforming care partnership for support to those with Learning disabilities and autism
- Additional relationship and staffing support for Mental Health patients in the community

These services strive to develop stronger local communities to support local residents to lead more active, socially engaged lives by addressing the wider, nonmedical needs of individuals with the provision of asset-based community programmes.

One of the main ways the Integrated Care Board (ICB) ensures meeting the Public Sector Equality Duty (PSED) is by undertaking an Equality Impact Assessment (EIA).

These help us to demonstrate we have considered the impact of policies, services and practices have on our patient population and our workforce, particularly those people with protected characteristics or those from inclusion health and vulnerable groups.

More information about this approach, as well as on the CORE20Plus5 approach for children and young people can be found at:
https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/

Core20Plus5 is the national approach to improving health equity and focuses on:

- The people in LLR who live in the 20% most deprived parts of England (whom we know have disproportionately poor access and outcomes)
- LLR seldom heard and underserved groups with additional barriers to good outcomes, such as those with learning disabilities, ethnic minority groups, carers and older people; and
- Five key clinical areas which are known to have the greatest adverse impact on life expectancy and healthy life expectancy.

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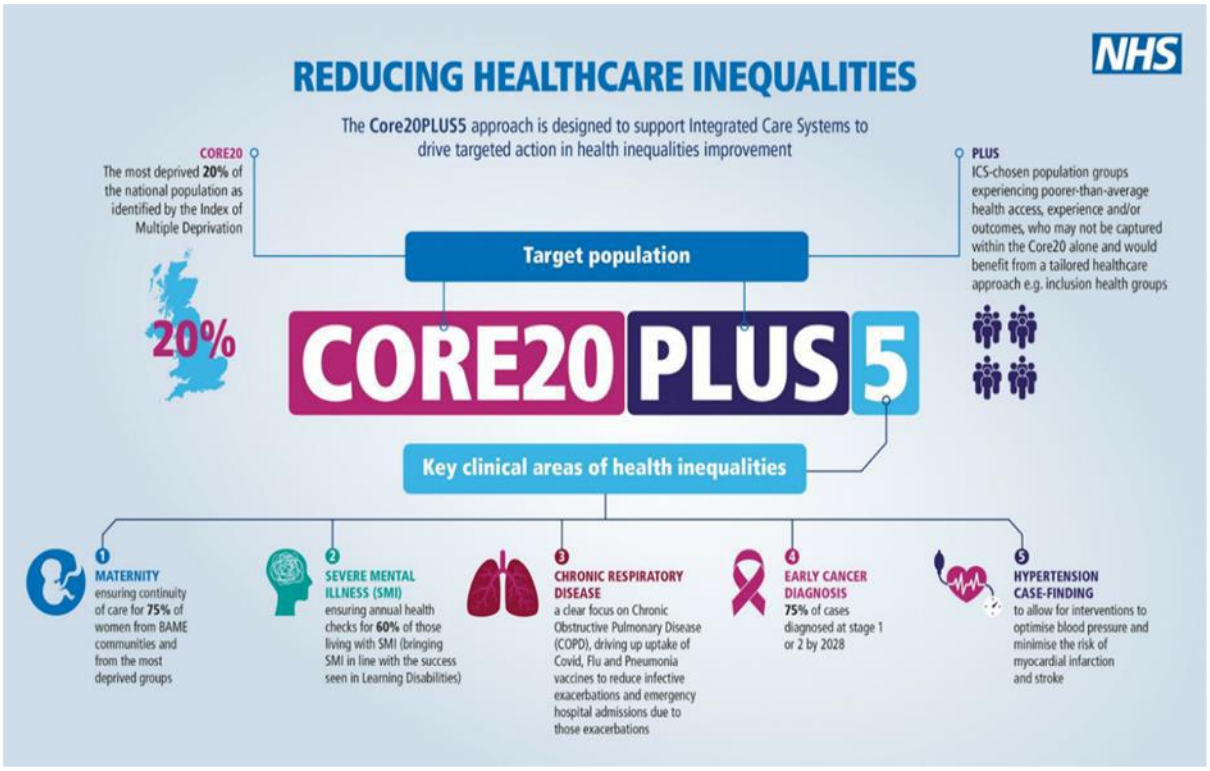

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Better Care Fund Scheme Review 2025

BCF- Key lines of Enquiry

Scheme Name:	**First Contact Plus- Leicestershire County Council, Public Health**		
Scheme Category:	Public Health		
Provider:	Leicestershire County Council – Public Health		
Lead Officer:	Simon Dalby (Head of Service) and Danny Saines (Operations Manager)		
2024/25 Expenditure:	£ 187,845	**2025/26 Forecasted Expenditure Requirement:**	£199,120
Staffing:	*Employed by FTE*		
Contract or framework agreement?	Agreement in place. Due to service restructure, it would be beneficial to understand this agreement in more detail		
Start Date:		**End Date:**	
Detail *(if yes, Procurement status, Longevity of scheme)* Longevity of Scheme 16 years. First Contact Plus has been established for 16 years based within both Adult Social Care and Public Health Departments. The service sits as a delivered service as part of Leicestershire County Council and directly employs a workforce to deliver the service.			
Service Description			
Detail of service provision /benefits of the scheme First Contact Plus is the first contact point for information, support and advice on a range of areas of need including Improving Your Health, Living Independently, Money, Debt and Benefits, Falls, and Feeling Safe for residents of Leicestershire. It provides an early intervention service offering referrals and signposting, dependent on need, to any Leicestershire resident over the age of 16. Each customer will receive a one to one triage call from a skilled advisor who will utilise a non-scripted holistic approach and identify the best solution for the customer at			

that time. The service works in partnership with other professionals across the county who specialise in wide ranging support offers and gives the ability for professionals to follow the customer journey from initial triage, through to referral and subsequent follow up evaluation through a professional portal. Professionals also benefit from being able to complete one referral form for a range of customer needs which can then be managed by a First Contact Plus advisor rather than having to make numerous referrals to a range of organisations. This allows them time to spend doing their specialist role rather than creating multiple referrals for a single customer.

Customers are contacted by an advisor within five working days and any customer that is identified as a high priority e.g. high risk of falls, palliative patient, safeguarding concern will be contacted within one working day. First Contact Plus sits inside the prevention agenda whereby a customer who has an intervention with First Contact Plus will be able to increase their independence, health outcomes, and life fulfilment by being referred to the right services at the right time for their ongoing need. This in turn reduces the impact on more specialist health and social care services as the customer has reduced, delayed, or eliminated the impact of their ongoing issue before it deteriorates further and therefore needing these more intensive and costly services.

In addition, First Contact Plus acts as the front door to Public Health Services in Leicestershire which includes services such as Quit Ready, Leicestershire Weight Management Service, Warm Homes and Local Area Coordination. Through this one main streamlined referral route a customer can access a vast range of support services that could support them whether identified originally by the original referrer or subsequently by having a triage conversation with a First Contact Plus advisor maximising the opportunities for individuals to access the right service, at the right time and to utilise prevention services and guide individuals to community based and universal offers to improve outcomes and protect services which are under high demand.

Outcomes

Detail of intended outcomes

- Reduce need for more intense support with health and social care services
- Increase independence and life fulfilment for customers
- Reduce risk of falls, breakdown in care, fire risk, safeguarding concerns, crime and negative health implications
- Increase engagement with support services and the wider local community
- Creating a healthier Leicestershire adult population
- Increase in numbers of referrals for health behaviour change
- Increase time available to professionals to do their specialist role

Business Case	*Is the scheme supported by a Business Case- Yes/No? (Request a copy if yes)*

KPI's or Targets	*Does the scheme have existing KPI's/Targets- Yes*
KPI's or Targets	*Please list current KPIs for performance management* Inbound Referral Numbers 24/25: Apr 24 – 599 May 24 – 571 June 24 -542 July 24 – 599 Aug 24 – 548 Sept 24 – 504 Oct 24 – 495 Nov 24 -504 Dec 24 – 360 Jan 25 – 577 Female – 59.3 % Male – 39.2 % Other – 1.4 % Age 16-19 – 0.5 % 20-29 – 2.8 % 30-39 - 4.4 % 40-49 - 6.6 % 50-59 - 11.2 % 60-69 - 12.9 % 70-79 - 23.2 % 80-89 - 29.2 % 90-99 – 7.6 % 100+ - 0.3 %

	Local Authority Blaby – 12 % Charnwood – 31.6 % Harborough – 9.9 % Hinckley and Bosworth – 15.8 % Melton – 6.2 % North West Leicestershire – 16.4 % Oadby and Wigston – 5.3 % Armed Forces Connection – 5.4 % Highest MSOA Referral Area 1. Loughborough Lemyngton and Hastings 2. Thurmaston 3. Mountsorrel and Rothley 4. Loughborough Outwoods 5. Loughborough Storer and Queen's Park 6. Markfield and Thornton 7. Ibstock and Ellistown 8. Agar Nook 9. Lutterworth 10. Birstall Wanlip and Riverside Falls Prevention services: 361 Lifeline Providers: 256 Care Technology, Lightbulb and Adult Social Care: 735

	Information and Advice Information and advice are given for customers to utilise the information themselves if they would prefer to do this rather than a referral be sent. Falls Prevention: 155 Lifeline and Care Technology: 151 Lightbulb Services: 56 Adult Social Care: 177
How does this meet BCF KPI's	
Contributes to the reduction of admissions to hospital Contributes to the reduction of Falls admissions	
Additional comments	

Unique Identifier	

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Meeting	Community Care Partnership (CCP)	**Date**	Tuesday 10th Dec 24
Title	**LLR Long-Term Pathway 2 Options Appraisal**		
Author	Verity Marlow: LLR D2A Programme Manager (secondment ICS post) and LLR System Discharge Lead (substantive ICS post)		
Presented By	Tasneem Lakdawala: ICB Head of Transformation UEC and Home First and ICTSG SRO Lisa Carter: County Service Manager for Health and Care Integration		
Endorsed by (added)	Tracy Ward: County Assistant Director for Integration, Access, and Prevention and ICTSG SRO		
Collaborators	Intermediate Care Transformation Steering Group (ICTSG) and the three ICT subgroups: P1 Subgroup, P2 Subgroup, and the Decision-Making Subgroup CHS Flow Group Discharge Cell		
Executive Leads for CCP	Director for CHS (LPT), Sam Leak Director for City ASC, Ruth Lake		
Action Required of CCP	See below		

To approve ☒	For assurance ☐	**To receive and note** ☒	For information ☐
For recommendation or course of action prior to presenting to LLR Exec Team	*To offer assurance for the LLR exec Team that controls and assurances are in place*	*Receive and note implications which may require discussion prior to presenting to LLR Exec Team*	*For note: for intelligence without in-depth discussion prior to presenting to LLR Exec Team*

Purpose of Paper	The purpose of this options appraisal is to seek approval from the LLR Exec Team to mobilise a Pathway 2 service across LLR that provides both D2A assessment 'and' intermediate care for all LLR residents with 24hr care needs requiring discharge from the acute setting, thus: • providing an equitable offer for all • mobilising system P2 IC/D2A capacity that meets demand • improving long-term outcomes for LLR residents • ensuring value for money
Appendices	Yes
Recommendation for CCP	**NOTE** the system data and intelligence provided which informs the long-term options and recommendation. **APPROVE** the options appraisal prior to being presented to the LLR Exec Team.
Report History	In September 2023 a paper was presented by the ICB on behalf of the system, detailing the Pathway 2 bedded settings utilised across LLR at that time. The paper was titled 'Overview of the LLR Intermediate Care Model Proposal for Out of Hospital Bedded Services' and supported the change in provision from the P2 Therapy Led Beds to the P2 High Dependency Beds commissioned from April 24. In early 2024, a system decision was made to recruit a LLR D2A Programme Manager (ICS role: secondment) to continue the demand, capacity, LOS, and outcomes review of all Pathway 2 patient cohorts residing in Pathway 2 bedded settings within LLR, to formulate an options appraisal on behalf of ICTSG to inform the long-term plan for Pathway 2 in LLR from April 25 onwards. The post holder commenced late May 24.

LLR Long-Term Pathway 2 Options Appraisal

1.0 Executive Summary

Whilst navigating national policy and guidance, since early 2023 the Intermediate Care Transformation Steering Group (ICTSG) has been mobilising plans to ensure that Pathway 2 services across LLR provide both Discharge to Assess (D2A) 'and' intermediate care (IC) for all LLR residents with 24hr care needs requiring discharge from the acute setting, to: provide an equitable offer for all, to mobilise system P2 IC/D2A capacity that meets demand, to improve long-term outcomes for LLR residents, and to ensure value for money. Whilst most of the P2 objectives recommended by UEC Improvement Expert Ian Sturgess and Newton Europe have since been achieved by ICTSG, final proposed plans for long-term P2 IC/D2A bedded settings in our system require LLR Exec Team consideration, agreement, and sign-off before mobilisation.

Based upon system P2 data and intel, ICTSG acknowledges that the considerable gap in system P2 IC/D2A bedded capacity to meet the demand of the 24hr residential care needs cohort needs resolving long-term. Additionally, that the system needs to finalise the long-term plans for the system P2 IC/D2A bedded capacity already in place for patients with 24hr bariatric and 24hr high dependency. For this reason, ICTSG recommends that system finance is agreed long-term to fully embed the commissioning arrangements for the P2 Bariatric Therapy Led beds and the P2 High Dependency beds.

In terms of recommending the long-term P2 plan for patients with 24hr residential care needs, this is more complex due to there being three viable options of six, because there is the need for a system led review of LLR Primary Care and Community Health Services to confirm if it would be possible for medical-step down patients to be discharged home directly from the acute setting to release P2 IC/D2A capacity for patients with 24hr care needs, and because the final agreed option/s for mobilisation are dependent on system finance.

Finally, acknowledging the increase in acute hospital admission rates each year, seasonal variation, and planning for surge capacity, ICTSG requests that the LLR Exec Team consider the option of mobilising and utilising P2 IC/D2A system beds at 85% occupancy, rather than the current 95-100% occupancy rate; understanding the challenges with increasing the system workforce and the demand on system finance to manage an occupancy rate of 85%.

2.0 Introduction and Context

In March 2020 the focus for hospital discharge changed at pace because of the Covid-19 pandemic. Therefore, following national guidance LLR moved to the 'Discharge to Assess' (D2A) model to embed home first principles and enable assessment of long-term care needs within the community rather than within the acute hospital setting. To enable the approach, the LLR Discharge Hub was mobilised to process Pathways 1, 2, and 3 discharge for all LLR residents requiring new or increased care upon discharge from hospital. Whilst navigating the challenges of the Covid-19 pandemic, all LLR partners worked collaboratively to embed robust Pathway 1-3 function through the LLR Discharge Hub and Integrated Discharge Team (IDT) and used system P1-3 data to inform ongoing transformation and strategic planning for P1-3 discharge.

During recovery from the Covid-19 pandemic in 2023 both nationally and locally, further government guidance was launched recommending that health and social care systems focus on delivering intermediate care services in unison with the D2A model. During 2024 national guidance continued to recommend that Pathway 1 and Pathway 2 intermediate care services are provided by health and social care professionals for up to four weeks/28 days after discharge from hospital to support people's recovery, rehabilitation, and reablement; the aim being to help people regain function, skills, and confidence, maximise independence, and to improve their longer-term outcomes:

- Delivery Plan for the Recovery of Urgent and Emergency Care Services (DHSC, Jan 2023)
- Managing Transfers of Care: High Impact Change Model (LGA, 2023)
- Intermediate Care Framework for Recovery, Rehabilitation, and Reablement following Hospital Discharge (NHSE, Sept 2023)
- A New Community Rehabilitation and Reablement Model (NHSE, Sept 2023)
- Hospital Discharge and Community Support Guidance (DHSC, Jan 24)

In view of the guidance, in March 2023 the Intermediate Care Transformation Steering group (ICTSG) formed and, with the support of Newton Europe (NE) through the Local Government Association, the group commenced a programme of work to review and embed Pathway 1 and 2 intermediate services across LLR. Prior to the review by NE, UEC Improvement Expert Ian Sturgess had also visited LLR and reviewed the approach within our system; the reports from both NE and Ian Sturgess shared that:

- There were ***too many P2 bedded settings*** in use across LLR creating inequity and confusion
- There was an ***inequitable P2 intermediate care*** (IC) offer; intermediate care was provided within some P2 bedded settings, and not others
- 34% of patients discharged to our Pathway 2 bedding settings were ***not residing in the ideal P2 setting to meet their needs***
- 41% of patients discharged to a P2 Residential Care Home bed ***could have returned home with Pathway 1*** but noted the ***lack of Pathway 1 intermediate care capacity*** and reliance on the domiciliary care market
- 35% of delay in discharge planning was driven by ***lack of Pathway 2 intermediate care capacity***
- ***Poor patient outcomes:*** 60% of LLR residents remained in long-term bedded care after the D2A assessment period in the P2 bedded setting, because IC had not been provided

As a result of the findings, the ICTSG mobilised three system led subgroups and developed a comprehensive programme plan for each group: ICT Pathway 1, ICT Pathway 2, and ICT Decision Making. Consequently, from March 2023 to April 24 the following outcomes were achieved to resolve the identified concerns:

- ***Mobilisation of P1 intermediate care services*** delivered by each of our three Local Authorities: City, County, and Rutland. Now in 2024, on average (see appendix 1):
    - 85% of patients are discharged with P1 support
    - 12% to a P2 Residential Care Home bed
    - 3% discharged by P3

- ***IDT decision making with the patient at ward level across all LLR hospitals***, determining the most appropriate discharge plan and pathway (see appendix 1 and 2):
    - enabling P1 discharge, not to P2 bedded settings
    - increasing P1 discharge and reducing Pathway 2 discharge
    - reducing LOS from 'MOFD to actual discharge' by approx. 50%

- ***On average 81% of patients requiring P2 support are now discharged to our P2 Community Hospitals Beds which provide intermediate care*** (with a target of 90% by April 25), and ***a further 4% of patients are discharged to our other system P2 bedded settings which provide intermediate care*** (see appendix 3):
    - Supporting equity and improving patients' long-term outcomes

- *By Oct 24,* ***eliminating P2 discharge from our P2 Community Hospital Beds, as intermediate care and D2A assessment is carried out within that system P2 bedded setting*** (see appendix 4)***:***
    - Improving the patient experience and their long-term outcomes

A further key objective for ICTSG to fully achieve, is to streamline Pathway 2 services within LLR and eliminate the use of P2 bedded settings that do not offer intermediate care, hence the purpose of this options appraisal.

3.0 Current P2 Offer and Position

Through the ICT programme plans led by ICTSG, work was undertaken to ensure system led P2 bedded settings were mobilised and managed through the LLR Discharge Hub, that support both intermediate care and D2A assessment and meet the care needs of our differing P2 cohorts. The below shows the current system P2 IC/D2A bedded settings and P2 cohorts within LLR:

P2 System Bedded Setting: IC provided	P2 Cohort
P2 CoHo Beds at Charnwood Ward in LPT	24hr Nursing Needs
P2 High Dependency Beds in a LLR Care Home	24hr High Dependency Needs
P2 Bariatric Therapy Led Beds in LLR Care Homes	24hr Bariatric Needs
P2 CoHo Beds at Coalville Ward 4 in LPT	24hr Residential Care needs
P2 CoHo Beds across LPT	24hr Medical Step Down (MSD), Palliative Care, and General Rehab

Note: through a separate workstream supported by our system QI Leads, UHL and LPT are collectively reviewing the P2 Stroke Pathway bedded offer in LLR. Therefore, that P2 setting/cohort is excluded from this options appraisal.

Once the LLR D2A Programme Manager commenced in post in late May 24, they collaborated with all system partners and their respective Business Intelligence Teams to collate, review, and analyse Pathway 2 data from all LLR databases. The system P1-3 database aligned to the LLR Discharge Hub, called the S1 Discharge hub Unit, was used alongside all individual partner databases; the P2 data shared from partner databases, mirrored the P2 data shared from our system database:

- System: S1 Discharge Hub Unit
- UHL: NerveCentre and Qlik
- LPT: S1 CoHo Unit
- ASC: LAS (for our Local Authorities)
- MLCSU/ICB: CMS

Through analysis of such P2 data spanning Aug 22 to July 24 (2yr period), a data report was shared across the system confirming our current demand, capacity, LOS (in/out flow), and outcomes for all Pathway 2 bedded settings and P2 patient cohorts. The data report highlights the gap in LLRs provision of P2 beds that support both intermediate care and D2A assessment (see appendix 5), as per the summary below.

P2 Cohort	Ave. Yearly P2 Bed Demand	P2 IC/D2A Beds Insitu	Ave. Yearly P2 Bed Gap	Plans
24hr Nursing Needs	13	13	0	Updated Nov 24 by LPT: capacity now meets demand
24hr High Dependency needs	11	15	+ 4	ICB anticipating full utilisation over winter 25/26
24hr Bariatric Needs	6	2	- 4	ICB increasing bed base by four, By Dec 24
24hr Medical Step Down (MSD), Palliative Care, and General Rehab	204	204	0	Capacity meets demand
24hr Residential Care Needs (City and County LA residents only)	**103**	**15**	**- 88**	**No system agreed plans in place to meet the demand**

Note: the above data is based upon a 100% occupancy rate, with such being the systems' current approach.

Currently there are beds hosted by UHL situated on Wd 22 LGH and The Ashton Care Home, that are an extension of the UHL bed base and opened across Aug-Sept 22, due to the number of patients residing in the acute with no reason to reside. However, such beds are utilised internally within UHL only and not via the LLR Discharge Hub, with a hybrid operating model supporting P0-P3 patients. Additionally, a proportion of patients are discharged from those settings, into system P2 beds (see appendices 6 and 7). Therefore, the yearly demand for the P2 patients supported in those beds

is included within the overall P2 bed demand versus capacity data (see appendix 5); with the right P2 option mobilised within LLR, such patients would no longer need to remain residing in UHL once medically optimised for discharge with no reason to reside.

In view of the data and intel provided, it indicates that the main focus for LLR is to agree and mobilise a P2 bedded setting that provides an equitable intermediate care offer for the 24hr residential needs cohort, for City and County LA residents; with Rutland LA already providing a P2 IC/D2A offer for their own LA residents. The aim being to mobilise a long-term P2 service that meets the yearly demand for the 24hr residential care needs cohort and closes the P2 IC/D2A bed gap, whilst also finalising our long-terms plans for the other three cohorts highlighted above.

4.0 Equity and Quality

Enabling LLR residents to stay well, safe, and independent at home for as long as possible has been long standing policy for our health and social care system, locally and nationally. As set out in 'Intermediate Care – Halfway Home' (DoH, 2009), not only should health and social care systems focus on the provision of intermediate care services (IC), but IC services that are equitable and provide quality care. Additionally, both equity and quality remain key themes within recent guidance mentioned earlier in section 2, and within Lords Darzi's report, 'Independent investigation of the NHS in England', shared nationally in Sept 2024. Therefore, on behalf of the system, ICTSG are dedicated to ensuring that the P2 IC/D2A services mobilised long-term within LLR are inclusive, caring, safe, effective, responsive, and well-led.

In view of the above, throughout the P2 options shared within the next section of the paper, there is focus on:

- Managing all P2 IC/D2A bedded settings through the leadership and function of the LLR Discharge Hub
- Reducing the LOS from 'MOFD to actual discharge', thus reducing the impact of potential deconditioning in the acute setting whilst the patients wait for their P2 IC/D2A bed
- Ensuring 'all' LLR residents receive intermediate care in the P2 bedded setting that they are discharged to
- Ongoing collaboration of our health and social care teams to ensure safe/effective care and assessment during the IC/D2A period
- Applying 'home first' principles in the P2 bedded setting, with the focus being to support eventual discharge home where possible
- Enabling P2 IC/D2A support and assessment within the P2 bedded setting, to ensure eventual discharge within 4 weeks/28 days of arrival i.e. discharge home with or without a POC, or to a long-term bed

Additionally, ensuring continued involvement of the patient and their NOK or main carer, during the IC/D2A assessment period, to ensure we remain focussed on the voice of the person (VoP).

Note: the term 'LLR residents' refers to people living within our health and social care system who LLR are responsible for discharging from the acute setting, either because the person resides within a LLR Local Authority, and/or because they are registered with a LLR General Practitioner.

5.0 Pathway 2 Options Explored

As shared earlier within section 3, much work has already occurred through ICTSG to streamline our P2 bedded settings that provide intermediate care and meet the differing needs of our P2 patient cohorts. However, consideration and sign-off by the LLR Exec Team is required to mobilise an equitable long-term P2 IC/D2A offer for the 24hr residential needs cohort, that meets the yearly demand. Therefore, the options below have been evaluated, for consideration:

Potential Options for P2 24hr Residential Needs Cohort
A) Do nothing: ASC continue to spot purchase Residential Care Home (RH) beds within the LLR Care Home Market without a system intermediate care (IC) offer, with or without standard LPT Community Therapy input via SPA
B) Procure 2 x 24hr carers in the patients' home, providing IC with the support of Community Therapy
C) Mobilise Grace Dieu Ward in LPT long term, with an onsite intermediate care offer
D) Limit or cease the number of sub-acute patients who transfer to LPT from UHL into a medical step-down bed (MSD), and instead re-model the beds to provide an onsite intermediate care offer for the 24hr residential needs cohort who are MOFD
E) Procure 'RH beds and staffing' within existing privately run Residential Care Homes in LLR, and provide intermediate care with onsite support from ASC, Community Therapy and Community Care Home Training Team
F) Procure 'the building, beds and staffing' within a previously run private Residential Care Home in LLR, and provide intermediate care with onsite support by Nurses, Community Therapy, and ASC. The system will also need to run and maintain the estate, with the respective staffing resource

As outlined in appendix 8, there are several implications to consider for options A-F, due to: the complexities with caring for patients with 24hr residential care needs (see appendix 9), ensuring timely transfer of care from the acute, providing a safe environment in the community that meets the cohorts needs, and a model that supports both intermediate care and D2A assessment to enable positive long-term outcomes. For this reason, a summary for each option has been provided below relating to demand, quality, equity, safety, and financial impact markers:

Option	Beds Supported for Gap of 88 Beds	DC Hub led End to End inc. data	7 day/Late Admission	Ave. LOS: MOFD to DC	IC Provided	Onsite IDT Approach	24hr Nursing Cover	24hr Medical Cover	VoP Inc. During Assessment	Positive Patient Outcomes	Financial Impact
A	1-88	✗	✗	10 days	✗	✗	✗	✗	✓	✗	High
B	1-88	✗	✗	2 days	✓	✗	✗	✗	✓	?	High
C	1-19	✓	✓	2 days	✓	✓	✓	✗	✓	✓	Moderate
D	1-70	✓	✓	2 days	✓	✓	✓	✗	✓	✓	Moderate
E	1-88	✗	✗	2 days	✓	✓	✗	✗	✓	✓	Moderate
F	1-88	✓	✓	2 days	✓	✓	✓	✗	✓	✓	High

Note: there is a 10 day LOS from 'MOFD to discharge' for patients transferring to privately owned Residential Homes, as the Discharge Hub and IDT are beholden to the care home market for decision making and bed availability. Whereas the LOS is just two days for P2 IC/D2A beds managed by the system, as the decision making and bed allocation process is manged solely by the LLR Discharge Hub and IDT.

Based upon the available data and intel, such suggests that the options meeting the demand, quality, equity, safety, and financial impact markers for the 24hr residential needs cohort, are options C, D and F:

Possible Options for P2 24hr Residential Needs Cohort
C) Mobilise Grace Dieu Ward in LPT long term, with an onsite intermediate care offer
D) Limit or cease the number of sub-acute patients who transfer to LPT from UHL into a medical step-down bed (MSD), and instead re-model the beds to provide an onsite intermediate care offer for the 24hr residential needs cohort who are MOFD
F) Procure 'the building, beds and staffing' within a previously run private Residential Care Home in LLR, and provide intermediate care with onsite support by Nurses, Community Therapy, and ASC. The system will also need to run and maintain the estate, with the respective staffing resource

In terms of the long-term plans for the P2 cohorts below:

- 24hr High Dependency Needs cohort
- 24hr Nursing Needs cohort
- 24hr Bariatric Needs Cohort

as mentioned in section 3, the system mobilised P2 IC/D2A beds to support the intermediate care needs for these cohorts (see appendices 10, 11 and 12), with plans in place to increase the beds to meet the overall demand (see appendix 5). However, such P2 bedded settings require consideration and sign-off by the LLR Exec Team as the long-term solutions. Therefore, the below summaries the demand, quality, equity, safety, and financial impact markers for those system P2 IC/D2A bedded settings:

P2 Cohort/Beds	Total Bed Demand Met	DC Hub led End to End inc. data	7 day/Late Admission	Ave. LOS: MOFD to DC	IC Provided	Onsite IDT Approach	24hr Nursing Cover	24hr Medical Cover	VoP Inc. During Assessment	Positive Patient Outcomes	Financial Impact
P2 TL Bariatric Beds: 24hr bariatric	✓	✗	✗	5 days	✓	✓	✓	✗	✓	✓	No Change
P2 Charnwood Wd: 24hr nursing	✓	✓	✓	2 days	✓	✓	✓	✗	✓	✓	No Change
P2 HD Beds: 24hr high dependency	✓	✗	✗	6 days	✓	✓	✓	✗	✓	✓	No Change

6. Recommendations by ICTSG

<u>24hr Residential Needs Cohort</u>

Based upon the review of all available data and intel by ICTSG, and considering the purpose of this options appraisal and the markers mentioned in sections 4 and 5, the group does not recommend options A, B or E for the 24hr residentials needs cohort:

Options *'not recommended'* for P2 24hr Residential Needs Cohort
A) Do nothing: ASC continue to spot purchase Residential Care Home (RH) beds within the LLR Care Home Market without a system intermediate care (IC) offer, with or without standard LPT Community Therapy input via SPA
B) Procure 2 x 24hr carers in the patients' home, providing IC with the support of Community Therapy
E) Procure 'RH beds and staffing' within existing privately run Residential Care Homes in LLR, and provide intermediate care with onsite support from ASC, Community Therapy and Community Care Home Training Team

Option A would leave the system in status quo with 13% of LLR residents still continuing to wait 10 days in the acute setting whilst MOFD for allocation of a standard P2 D2A RH bed; increasing potential risk of deconditioning, LLR would remain beholden to the care home market for this cohort; impacting on system flow and finance, patients would still not receive an intermediate care offer in the community; resulting in poor patient outcomes and long-term bedded care, and the Discharge Hub and IDT would still not have end to end oversight of the entire hospital discharge to D2A assessment process.

Whilst **Option B** would support patients to return home with an intermediate care offer, this option presents risks for patient safety in the community, challenges around the Human Rights Act (ECHR, 1998) and the Mental Capacity Act and Deprivation of Liberty Safeguards (DCA, 2005), challenges with avoiding hospital admission if the 24h care at home did not meet need as there is not yet a robust step-up model mobilised in LLR to meet demand, long-term patient outcomes are uncertain as this model has not been fully trialled in LLR before, and the Discharge Hub and IDT would not have end to end oversight of the entire hospital discharge to D2A assessment process. Furthermore, it is a high cost model for LLR to operationalise.

In terms of **Option E,** in recent years this model has been trialled within LLR through the block booked arrangements in the P2 Sovereign Unit and P2 Therapy Led bedded settings. During the time the bedded settings were in operation, as

with Option A the system was beholden to Residential Home (RH) management teams for decision making and confirming bed availability with such teams being accountable for the private business arrangements and CQC registration of those care homes. Therefore, most frequently only patients with assistance of one (Ao1) and lower-level care needs would be accepted, not patients with 24hr residential care needs who required assistance of two (Ao2) and higher-level support (see appendix 9 for varying needs of this cohort). Thus, resulting in empty beds in those P2 settings daily, a poor occupancy rate, poor value for money, and City and County ASC instead needing to broker standard P2 D2A RH beds without an intermediate care offer for the 24hr residential care needs patients not accepted. Therefore, the system agreed that those bedded settings were no longer fit for purpose, the beds were decommissioned in April 24, and the patients with Ao1 care needs were instead discharged home with the support of our in-house P1 intermediate care services delivered by our Local Authorities.

Again, based upon the review of all available data and intel by ICTSG, and considering the purpose of this options appraisal and the markers mentioned in sections 4 and 5, the group recommend options C, D and F as viable long-term options for the 24hr residentials needs cohort:

'Recommended' **Options for P2 24hr Residential Needs Cohort**
C) Mobilise Grace Dieu Ward in LPT long term, with an onsite intermediate care offer
D) Limit or cease the number of sub-acute patients who transfer to LPT from UHL into a medical step-down bed (MSD), and instead re-model the beds to provide an onsite intermediate care offer for the 24hr residential needs cohort who are MOFD
F) Procure 'the building, beds and staffing' within a previously run private Residential Care Home in LLR, and provide intermediate care with onsite support by Nurses, Community Therapy, and ASC. The system will also need to run and maintain the estate, with the respective staffing resource

The rational for ICTSG recommending these options is because not only are the markers mentioned in sections 4 and 5 met, all three options support the systems' ambition to mobilise a Pathway 2 service across LLR that provides both D2A assessment 'and' intermediate care for all LLR residents with 24hr care needs requiring discharge from the acute setting, thus:

- providing an equitable offer for all
- mobilising system P2 IC/D2A capacity that meets demand
- improving long-term outcomes for our residents
- ensuring value for money

In terms of the yearly bed gap of 88 x P2 IC/D2A beds for the 24hr residential care needs cohort, there is potential for the demand to be met by Options C and D combined, Options C and F combined, or Option F alone. However, in view of the systems' financial climate, position, and risks, the option/s to be agreed and mobilised requires steering from the LLR Exec Team as such depends on available system finance.

Additionally, whilst Option D is a viable option, a system led review of LLR Primary Care and Community Health Services is required to confirm if it would be possible for medical-step down patients to be discharged home directly from the acute setting, rather than transferring to P2 Community Hospital beds, to release that P2 IC/D2A bedded capacity for patients with 24hr care needs. For approximately 10 years the current system model has supported the MSD cohort in P2 CoHo beds, but recent data analysis indicates that most MSD patients who transfer to LPT have P0 or P1 social care needs upon discharge from the acute (see appendix 13), and transfer to the P2 CoHo bed for medical intervention and IC rather than having 24hr care needs that require P2 IC/D2A assessment. Therefore, with full scope, analysis, and planning for an alternative P1 system offer for the MSD cohort, there is opportunity to release up to 70 of the 204 beds aligned to the MSD/general rehab cohort in LPT (see appendix 5 and 8), for patients with P2 24hr residential care needs.

<u>24hr Bariatric, 24hr High Dependency, and 24hr Nursing</u>

In terms of patients with 24hr bariatric, high dependency, and nursing needs, as mentioned in section 3 and 5, there are already system P2 IC/D2A bedded settings in place within LLR to meet the needs of these cohorts, with existing plans in

place to meet the overall demand. Additionally, with the support of the LLR Discharge Hub, ongoing PDSA cycles and data analysis takes place within the system to monitor and review performance for those bedded settings, and to support ongoing transformation. However, the P2 High Dependency and P2 Bariatric Therapy Led bedded settings are yet to be agreed as the long-term solutions for these cohorts of patients, therefore ICTSG recommend that finance is agreed long-term to fully embed those commissioning arrangements:

P2 Cohort/Beds	Total Bed Demand Met	DC Hub led End to End inc. data	7 day/Late Admission	Ave. LOS: MOFD to DC	IC Provided	Onsite IDT Approach	24hr Nursing Cover	24hr Medical Cover	VoP Inc. During Assessment	Positive Patient Outcomes	Financial Impact
P2 TL Bariatric Beds: 24hr bariatric	✓	✗	✗	5 days	✓	✓	✓	✗	✓	✓	No Change
P2 Charnwood Wd: 24hr nursing	✓	✓	✓	2 days	✓	✓	✓	✗	✓	✓	No Change
P2 HD Beds: 24hr high dependency	✓	✗	✗	6 days	✓	✓	✓	✗	✓	✓	No Change

Note: the P2 beds on Charnwood Ward in LPT, for the 24hr nursing needs cohort, are already funded substantively.

On a final note, the current system agreement is to utilise P2 IC/D2A system bed at approx. 95-100% occupancy, hence the bed modelling shared within this paper. However, acknowledging the increase in acute hospital admission rates each year, seasonal variation, and planning for surge capacity, ICTSG request that the LLR Exec Team consider the option of instead utilising P2 IC/D2A system beds at 85% occupancy, and increase the suggested bedded capacity by 15% to support that approach; understanding the challenges with increasing the system workforce and the demand on system finance to manage an occupancy rate of 85%.

Appendix 1

The below shows the monthly and yearly percentage of P1-3 discharges from the acute setting, enabled by the LLR Discharge Hub and supported by our three local authorities. The data source is the S1 DC Hub Unit:

	2022					2022 Total	2023												2023 Total	2024									2024 Total	Grand Total
City	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
1	83%	77%	78%	80%	82%	80%	79%	82%	84%	73%	81%	87%	81%	88%	79%	82%	85%	87%	83%	90%	85%	83%	78%	87%	84%	86%	92%	85%	85%	83%
2	17%	23%	20%	19%	17%	19%	20%	15%	16%	24%	17%	9%	12%	10%	21%	18%	15%	13%	16%	9%	12%	12%	19%	11%	14%	8%	8%	12%	12%	15%
3	0%	0%	2%	1%	1%	1%	1%	2%	0%	2%	2%	4%	7%	2%	0%	0%	1%	1%	2%	1%	3%	5%	3%	3%	2%	5%	0%	3%	3%	2%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	2022					Total	2023												Total	2024									Total	Total
County	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
1	78%	71%	82%	77%	85%	78%	84%	84%	84%	81%	76%	89%	90%	83%	87%	82%	80%	78%	83%	86%	88%	88%	85%	83%	86%	85%	82%	87%	86%	83%
2	21%	28%	17%	22%	15%	21%	15%	15%	15%	18%	22%	11%	10%	15%	11%	18%	19%	21%	16%	12%	11%	8%	13%	14%	11%	11%	15%	10%	12%	15%
3	0%	1%	1%	1%	1%	1%	1%	1%	1%	0%	1%	0%	0%	2%	1%	0%	1%	1%	1%	1%	1%	4%	2%	3%	2%	5%	3%	3%	3%	2%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	2022					Total	2023												Total	2024									Total	Total
Rutland	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
1	38%	0%	86%	89%	67%	63%	100%	83%	100%	75%	67%	86%	60%	75%	67%	33%	100%	100%	73%	67%	50%	80%	100%	100%	88%	100%	100%	40%	79%	73%
2	63%	100%	14%	11%	33%	37%	0%	17%	0%	25%	33%	14%	20%	25%	33%	67%	0%	0%	24%	33%	50%	20%	0%	0%	13%	0%	0%	60%	21%	26%
3	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	20%	0%	0%	0%	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Appendix 2

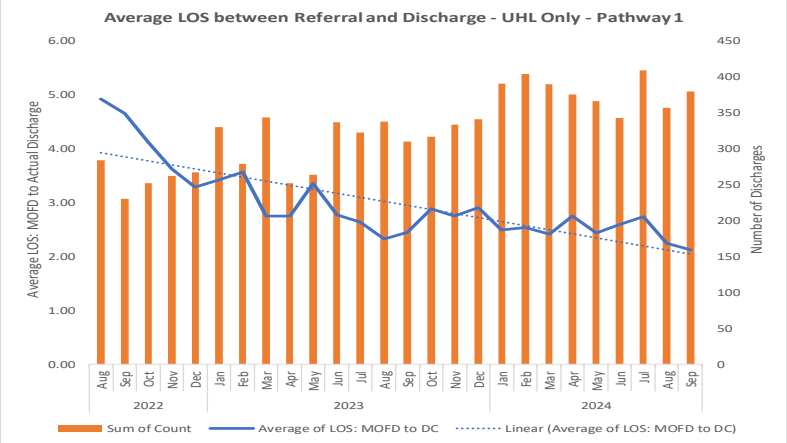
The below shows the monthly and yearly number of P1 and P2 discharges from the acute setting, and the LOS from 'MOFD to actual discharge', enabled by the LLR Discharge Hub and supported by all partners. The data source is the S1 DC Hub Unit.

Note: the LOS from 'MOFD to actual discharge' includes the additional LOS due to incomplete discharge .i.e. the discharge did not occur on the day planned due to a TTO delay

Pathway 1

Pathway	1

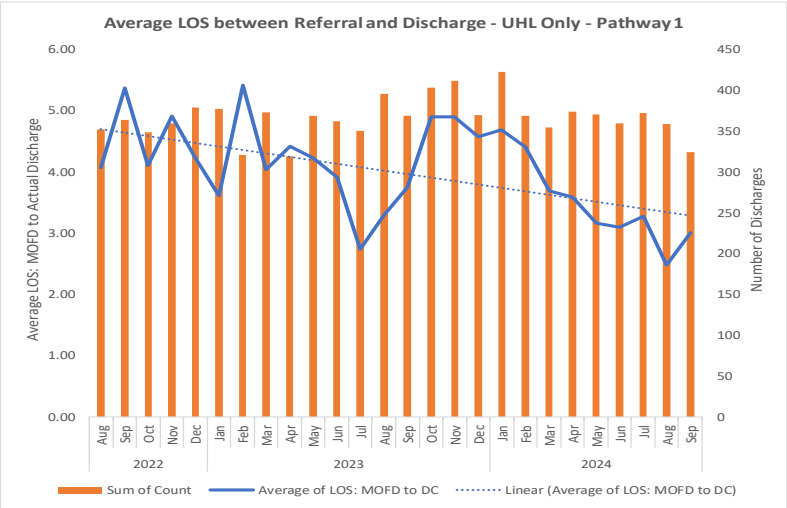
Row Labels	Average of LOS: MOFD to DC	Sum of Count
2022	**4.12**	**1295**
Aug	4.93	284
Sep	4.66	230
Oct	4.13	252
Nov	3.62	262
Dec	3.29	267
2023	**2.87**	**3769**
Jan	3.42	330
Feb	3.57	279
Mar	2.75	344
Apr	2.75	252
May	3.35	264
Jun	2.77	337
Jul	2.64	323
Aug	2.33	338
Sep	2.45	310
Oct	2.88	317
Nov	2.75	334
Dec	2.91	341
2024	**2.48**	**3416**
Jan	2.49	391
Feb	2.53	404
Mar	2.41	390
Apr	2.75	376
May	2.43	366
Jun	2.59	343
Jul	2.74	409
Aug	2.25	357
Sep	2.13	380
Grand Total	**2.90**	**8480**



Pathway 2

Pathway	2

Row Labels	Average of LOS: MOFD to DC	Sum of Count
2022	**4.54**	**1804**
Aug	4.08	352
Sep	5.37	364
Oct	4.10	349
Nov	4.91	360
Dec	4.24	379
2023	**4.15**	**4421**
Jan	3.61	377
Feb	5.42	321
Mar	4.04	373
Apr	4.42	319
May	4.23	369
Jun	3.92	362
Jul	2.73	350
Aug	3.30	396
Sep	3.75	369
Oct	4.90	403
Nov	4.90	412
Dec	4.57	370
2024	**3.52**	**3307**
Jan	4.69	423
Feb	4.41	369
Mar	3.69	355
Apr	3.59	374
May	3.16	371
Jun	3.10	360
Jul	3.27	372
Aug	2.48	359
Sep	3.01	324
Grand Total	**4.01**	**9532**



Appendix 3

The below data shows the total number and percentage of P2 discharges from the acute setting by month and year, by P2 bed type. The data source is the S1 DC Hub Unit.

- Highlighted in green shows the number and percentage of patients discharged to system P2 bedded settings where an equitable intermediate care offer is provided

- Highlighted in red shows the number and percentage of patients with 24h residential care needs, discharged to standard P2 Residential Home beds via City and County ASC where intermediate care is not provided as such beds are not system led or managed

- Highlighted in grey shows the P2 beds no longer in use, and the P2 Temporary Health Conditions (THC) cohort who do not have IC potential until their THC has resolved and therefore have their IC arranged in the community once THC Pathway support has ceased.

	2022					2022 Total	2023												2023 Total	2024									2024 Total
Partner/Pathway	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Bariatric TL Bed		2			1	3		1				1		1	1	1	1	2	8				1	1	2		2		6
City	19	24	21	19	19	102	24	13	16	20	17	10	14	12	23	23	19	16	207	12	18	17	27	13	16	12	8	15	138
County	45	49	32	45	26	197	37	30	40	39	45	26	23	35	24	39	48	52	438	35	29	22	37	38	29	29	41	27	287
LPT: CoHo	243	230	257	248	275	1253	257	231	268	234	261	273	274	299	268	285	307	267	3224	340	291	290	286	296	296	311	292	264	2666
MLCSU: HD	5	16	4	9	16	50	11	10	13	4	8	9	5	7	10	13	12	10	112	12	9	6	8	13	7	11	11	9	86
MLCSU: NH	11	15	14	15	15	70	16	18	9	8	16	19	16	19	20	9			150					3		1			4
Rutland	5	3	1	1	1	11		1		1	1	1	1	1	2	4			12	2	1	1			1			3	8
THC Pathway: City							1	1			1	1	2	2	2	2		2	14	3	3	2	3	4	3	1	1	5	25
THC Pathway: County				1	1	2			1	2	2	2	1	5	1	2	6	3	25	6	2	5	4	3	6	6	4	1	37
TL/Sov Unit Bed	24	25	20	22	25	116	31	16	26	11	18	20	14	15	18	25	19	18	231	13	16	12	8						49
Grand Total	352	364	349	360	379	1804	377	321	373	319	369	362	350	396	369	403	412	370	4421	423	369	355	374	371	360	372	359	324	3307

	2022					2022 Total	2023												2023 Total	2024									2024 Total
Partner/Pathway	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Bariatric TL Bed	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	1%	0%	1%	0%	0%
City	5%	7%	6%	5%	5%	6%	6%	4%	4%	6%	5%	3%	4%	3%	6%	6%	5%	4%	5%	3%	5%	5%	7%	4%	4%	3%	2%	5%	4%
County	13%	13%	9%	13%	7%	11%	10%	9%	11%	12%	12%	7%	7%	9%	7%	10%	12%	14%	10%	8%	8%	6%	10%	10%	8%	8%	11%	8%	9%
LPT: CoHo	69%	63%	74%	69%	73%	69%	68%	72%	72%	73%	71%	75%	78%	76%	73%	71%	75%	72%	73%	80%	79%	82%	76%	80%	82%	84%	81%	81%	81%
MLCSU: HD	1%	4%	1%	3%	4%	3%	3%	3%	3%	1%	2%	2%	1%	2%	3%	3%	3%	3%	3%	3%	2%	2%	2%	4%	2%	3%	3%	3%	3%
MLCSU: NH	3%	4%	4%	4%	4%	4%	4%	6%	2%	3%	4%	5%	5%	5%	5%	2%	0%	0%	3%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%
Rutland	1%	1%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%
THC Pathway: City	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	1%	0%	0%	1%	0%	1%	1%	1%	1%	1%	1%	0%	0%	2%	1%
THC Pathway: County	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	1%	0%	1%	0%	0%	1%	1%	1%	1%	1%	1%	1%	1%	2%	2%	1%	0%	1%
TL/Sov Unit Bed	7%	7%	6%	6%	7%	6%	8%	5%	7%	3%	5%	6%	4%	4%	5%	6%	5%	5%	5%	3%	4%	3%	2%	0%	0%	0%	0%	0%	1%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Appendix 4

The below shows the month-on-month reduction of P2 discharges from our P2 Community Hospital Bedded setting in LPT, and an increase in P0, P1, and P3 discharge. The data source is the S1 DC Hub Unit.

Date	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Trend
Pathway 0	41	28	50	66	63	37	55	55	62	79	61	73	74	60	
Pathway 1	146	150	142	142	132	158	141	124	157	156	147	156	152	125	
Pathway 2	34	37	37	41	32	41	39	47	24	26	19	15	6	3	
Pathway 3	4	1	1	1	7	4	12	13	13	8	19	21	31	33	
Total	225	216	230	250	234	240	247	239	256	269	246	265	263	221	

Pathway 0	18%	13%	22%	26%	27%	15%	22%	23%	24%	29%	25%	28%	28%	27%
Pathway 1	65%	69%	62%	57%	56%	66%	57%	52%	61%	58%	60%	59%	58%	57%
Pathway 2	15%	17%	16%	16%	14%	17%	16%	20%	9%	10%	8%	6%	2%	1%
Pathway 3	2%	0%	0%	0%	3%	2%	5%	5%	5%	3%	8%	8%	12%	15%

Note: the only discharges now occurring as P2 from LPT are for patients who have transferred as medical-step down (MSD) and during their stay their needs emerge as 24hr high dependency, or temporary health conditions (THC). Therefore, they are discharged to system P2 High Dependency beds, or via the THC Pathway.

Appendix 5: P2 Demand, Capacity, LOS, and Outcomes Data from Aug 22 to Aug 24, from all LLR system/partner databases (created Aug 24 and updated Oct 24)

P2 Patient Group	P2 Bed Type	Ave. Yearly P2 Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL: 24hr Residential Needs (exc. THC Pathway Cohort)	City: Spot RH Bed	212	16			31% home, 61% long term bed, 1% acute readmission, and 7% RIP Ave. LOS in the P2 bed is 32 days (28 in 2024)	Spot purchased. ***Oct 24:*** Framework in place until 30th June 25, but does not meet need ***Intermediate care (IC) not provided*** Ave. LOS from 'MOFD to DC into Bed' is 10 days
	County: Spot RH Bed	427	34			10% home, 42% no/SFunded service (POC/RH), 30% long term bed, and 18% RIP Ave. LOS in the P2 bed is 43 days (24 in 2024)	Spot purchased. ***Oct 24***: Framework in place until 30th June 25, but does not meet need ***Intermediate care (IC) not provided*** Ave. LOS from 'MOFD to DC into Bed' is 10 days
	UHL: The Ashton	82	6				Extra capacity beds until Aug 25 (in a RH)
	UHL: Wd 22 LGH	267	20				Extra capacity beds (onsite at LGH)
	LPT: Coalville Wd 4	170	13	15		24% home, 53% long term bed, 10% acute readmission, and 13% RIP Ave. LOS in the P2 bed is 28 days	Inc. in LPT Community Hospital bed base; opened Jan 24 for this cohort. ***IC provided.*** Ave. LOS from 'MOFD to DC into Bed' is 2 days Ave. bed occupancy is 96%
	UHL: Grace Dieu Wd	52: actual (Jan-March 24)	4				Opened between Jan and March to support winter 23/24 only. ***IC was provided***
LLR Pt OOA: 24hr Residential (exc. THC Pathway Cohort)	County: Spot RH bed	130	10			(as above for County)	As per the above for City and County re: spot purchase for UHL patients
		Total Patient Demand: 1340	**Total Bed Demand:** 103	**Total IC Bed Capacity:** 15	**Total IC Bed Gap:** **- 88**		***There is a 70% (County) v 30% (City) ASC split for the overall gap of 88 beds for this MOFD cohort: County = 62 beds and City = 26 beds***

Note: the ave. yearly patient demand includes total number of actual patient discharges. The yearly bed demand is calculated using a LOS of 28 days in the P2 bed for this cohort (13 pt per bed, per yr)

P2 Patient Group	P2 Bed Type	Ave. Yearly P2 Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL: 24hr Bariatric Needs (primarily ***social*** care needs)	Bariatric Therapy Led Bed at Aaron Court and Everdale Grange	12	2	2	0	53% home, 24% long term bed, and 23% readmission to acute Ave. LOS in the P2 bed is 58 days	Block booked Bariatric TL Beds are commissioned by the ICB until March 31st 25. ***IC provided.*** Ave. LOS from 'MOFD to DC into Bed' is 5 days
LLR Pt OOA: 24hr Bariatric (primarily ***social*** care needs)	Bariatric Therapy Led Bed at Aaron Court and Everdale Grange	4	(as above)	(as above)		(as above	(as above)
UHL: 24hr Bariatric Needs (primarily ***health*** care needs)	LPT: CoHo Bed	38	4	(none specific)	4	74% home, 9% long term bed, and 17% readmission to acute Ave. LOS in the P2 bed is 30 days ***IC provided.***	There aren't beds within LPT specifically commissioned for bariatric patients. Two beds close in LPT to support one bariatric patient, as staffing and bed capacity allows. Primary care needs for the cohort = 60% social and 40% health Ave. age is 65 yrs (mode is 63 yrs) Ave. LOS from 'MOFD to DC into Bed' is 5 days
		Total Patient Demand: 54	**Total Bed Demand:** 6	**Total IC Bed Capacity:** 2	**Total IC Bed Gap:** **- 4**		***The ICB are aiming to precure four more Bariatric TL beds across winter 24/25, until March 25***

Note: the ave. yearly patient demand includes total number of actual patient discharges, and the number of patients waiting this type of P2 bed each day. The yearly bed demand is calculated using a LOS of 42 days in the P2 bed for this cohort (9 pt per bed, per yr)

P2 Patient Group	P2 Bed Type	Ave. Yearly P2 Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL: 24hr Nursing Needs	LPT: Charnwood Wd	169	13	10	-3	15% home, 42% long term bed (43% NH and 57% RH) 24% readmitted to acute, and 19% RIP Ave. LOS in the P2 bed is 28 days ***IC provided.***	Patients are MOFD upon arrival on the Wd. Inc. in LPT Community Hospital bed base; beds opened Oct 23 long term LOS from 'MOFD to DC into Bed' is 7 days Ave. bed occupancy is 94%
		Total Patient Demand: 169	**Total Bed Demand:** 13	**Total IC Bed Capacity:** 10	**Total IC Bed Gap: - 3**		***LPT are aiming to provide three more beds from winter 24/25 onwards***

Note: the ave. yearly patient demand includes total number of actual patient discharges, and the number of patients waiting this type of P2 bed each day. The yearly bed demand is calculated using a LOS of 28 days in a P2 bed for this cohort (13 pt per bed, per yr)

P2 Patient Group	P2 Bed Type	Ave. Yearly P2 Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL: 24hr High Dependency	HD Bed at Everdale Grange	114	9	15		**<u>Shared by ICB in Oct 24:</u>** ***IC provided.*** 74% Long-term bed: 27% CHC, 31% FNC with or without 1:1, 13% Fast Track, 1% S117, and 28% RH. 13% home, 12% readmission, and 1% RIP. Ave LOS in the beds is 32 days (Apr-Sept 24)	Block booked beds commissioned by the ICB until June 25. Spot purchase beds are also brokered if HD patients are declined by Everdale Grange LOS from 'MOFD to DC into bed' is 6 days Occupancy in May to Sept 24 = 80%
LLR Pt OOA: **24hr High Dependency**	HD Bed at Everdale Grange	3	1	(as above)			(as above)
LPT: 24hr High Dependency	HD Bed at Everdale Grange	14	1				
		Total Patient Demand: 131	**Total Bed Demand:** 11	**Total IC Bed Capacity:** 15	**Total IC Bed Gap: + 4**		***The PDSA review by the ICB continues. The available beds will support winter 25/26***

Note: the ave. yearly patient demand includes total number of actual patient discharges, and the number of patients waiting this type of P2 bed each day. The yearly bed demand is calculated using a LOS of 28 days in the P2 bed for this cohort (13 pt per bed, per yr)

P2 Patient Group	P2 Bed Type	Ave. Yearly Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL and LLR Pt OOA: **24hr Rehab,** **Medical Step Down (MSD),** **and Palliative Care**	LPT: CoHo Bed Exc. 55 beds: Coalville Wd 4 x 15 Charnwood Wd x 10 Stroke Wds x 30			204	***** The P2 CoHo bed gap relates to Charnwood Wd, bariatric patients, and stroke rehab (as per above and below data/info) *****	85% home and 15% long terms beds/THC pathway Ave. LOS in the P2 bed is 21 days ***IC provided.***	Inc. in LPT Community Hospital bed base of 259 beds LOS from 'MOFD to DC into Bed' is 2 days, which includes the additional LOS due to incomplete transfers (aka delays) Ave. bed occupancy is 93% (acknowledging delayed transfer of patients)
				Total IC Bed Capacity: 204			***34% of all patients who transfer into a P2 CoHo bed are sub-acute with medical step down needs.***

Note: Whilst LLR hosts P2 stroke pathway beds across the system (2 rehab wards in LPT and 1 rehab ward in UHL), such neuro speciality beds are commissioned as per NHSE/NICE guidance, not D2A. Additionally, neuro recovery, rehabilitation, and reablement is already provided within those settings, alongside discharge planning and assessment by the LLR IDT. Therefore, demand and capacity modelling for the stroke rehab cohort is being managed by UHL and LPT collectively, with the support of the respective QI Leads

Appendix 6: Data to relating to UHL at The Ashton from Aug 22 to July 24, from system/UHL databases

Due to ongoing system challenges relating to the total number of medically optimised patients residing in University Hospitals of Leicester (UHL), in Aug 2022 UHL commissioned and mobilised 23 beds within The Ashton Care Home in Hinckley, as an extension of the UHL bed base. The beds were opened to specifically support flow for the Specialist Medicine (SM) CMG.

In preparation for mobilising the beds, UHL worked collaboratively with the LLR Discharge Hub to ensure the right cohort of patients were internally transferred to The Ashton, whilst they waited their discharge plan. Initially the aim was for the beds to be utilised for City and County LA residents waiting P2 D2A Residential Home beds via the Discharge Hub, but due to challenges with the estate and contract for The Ashton, the approach adapted to internal transfer of P0-3 patients from SM CMG. The challenges included: terms of CQC registration, availability of equipment, laundering and infection prevention, catering and infection prevention, and medical cover.

Up until May 2024, all patients of the P2 24hr residential care needs cohort who transferred to The Ashton received intermediate care by the UHL workforce based there, but did not receive D2A assessment by ASC. However, as part of our LLR intermediate care (IC) journey and recognising the provision of IC within that setting, from May 13th 2024 the IDT were mobilised to support D2A assessment alongside the IC offer at The Ashton. Therefore, from that date onwards patients with P2 24hr residential care needs who transferred to The Ashton no longer had a P2 D2A RH bed brokered but remained in that setting to complete their P2 IC/D2A period, and were discharged via P0, P1 or P3 only.

The below data collated by UHL using NerveCentre, indicates 417 x P2 patients transferred to The Ashton between Aug 22 and July 24 (2 year period), and shows the pathway the patient was discharged by. The data highlighted in green shows that 142 x patient's needs converted from P2 to P0 and P1.

Note: the S1 DC Hub Unit does not capture data regarding the internal transfers and P0 discharges as such is managed by UHL internally.

Discharge from The Ashton for P2 D2A Cohort

Count of Discharge Date	2022						2023													2024							
Row Labels	Aug	Sep	Oct	Nov	Dec	2022 Total	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 Total	Jan	Feb	Mar	Apr	Jun	Jul	2024 Total	Grand Total
P0			3	1	4	**8**	3	1	1	5	3	2	6	7	4	5	2	2	**41**	2			1			**3**	**52**
P1	1		7	1	2	**11**	6	4	9	2	5	9	5	6	2	1	10	4	**63**	8	3	2		2	1	**16**	**90**
P2		11	9	12	13	**45**	16	16	7	27	19	14	15	15	13	20	17	22	**201**	16	4	2	5		1	**28**	274
P3																									1	**1**	1
Grand Total	**1**	**11**	**19**	**14**	**19**	**64**	**25**	**21**	**17**	**34**	**27**	**25**	**26**	**28**	**19**	**26**	**29**	**28**	**305**	**26**	**7**	**4**	**6**	**2**	**3**	**48**	**417**

The below data collated from the S1 DC Hub Unit highlights all P1-3 discharges progressed by the LLR Discharge Hub from The Ashton between Aug 22 and July 24 (2 year period). The data highlighted in green indicates that 22 x patients were discharged by P3 via City and County from the date the P2 IC/D2A approach commenced at The Ashton.

Note: all P2 D2A RH bed discharges from The Ashton via City and County are included within the overall P2 D2A RH discharge data for all UHL patients via ASC between Aug 22 and July 24.

Count of Discharge Date	Co																												
	2022					2022 Total	2023												2023 Total	2024							2024 Total	Grand Total
Row Labels	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul		
Pathway 1	9	28	24	25	20	106	33	20	30	13	21	42	36	31	18	21	20	16	301	28	25	22	28	33	21	25	182	589
City	1	7	10	7	11	36	9	2	8	3	10	17	17	12	3	5	5	5	96	9	6	6	14	8	5	14	62	194
County	8	21	12	16	8	65	23	18	22	10	10	22	17	17	14	15	15	11	194	17	19	16	14	24	16	9	115	374
MLCSU: EOL			1			1						1							1					1			1	3
Rutland			1	2		3						1	1	1					3	1							1	7
THC Pathway: City					1	1	1					1	1	1		1			5							2	2	8
THC Pathway: County											1				1				2	1							1	3
Pathway 2	11	26	12	24	20	93	19	19	24	23	19	23	19	18	18	31	20	24	257	23	12	16	20	12	4	5	92	442
City	2	3	4	8	7	24	6	4	8	5	5	4	3	4	6	5	5	5	60	2	4	6	6	3	1	1	23	107
County	7	19	8	10	6	50	6	12	12	13	9	9	11	9	7	20	12	16	136	15	4	5	11	2	2		39	225
LPT: CoHo				2	4	6	3	3	2	2	1	4			3	3	2	2	25	3	3	1	2	5	1	1	16	47
MLCSU: HD	1	1			1	3							1						1					1		1	2	6
MLCSU: NH		1		1		2	2		2	2	2	3	3	3	2	1			20									22
Rutland		2		1	1	4								1					1				1				1	6
THC Pathway: City							1					1	1						3	1	1	1		1			4	7
THC Pathway: County				1	1	2					2	1		1		2	1	1	8	2		2	1			2	7	17
TL/Sov Unit Bed	1			1		2	1			1		1							3									5
Pathway 3		1	1	2		4		1	2	1	3	4	2	4	4		1	1	23	1	1	2	4	5	5	14	32	59
City											1	2	2	2					7		1		2		1	7	11	18
County			1	2		3		1	2	1	1	1		1			1	1	9			2	1	5	4	5	17	29
MLCSU: EOL		1				1					1	1		1	2				5	1			1			1	3	9
MLCSU: NH															2				2							1	1	3
Grand Total	20	55	37	51	40	203	52	40	56	37	43	69	57	53	40	52	41	41	581	52	38	40	52	50	30	44	306	1090

Summary

Based upon the available system data across a two year period, it indicates that 164 patients (ave. 82 a year) were supported by UHL at The Ashton, who would have otherwise required a P2 D2A RH bed via ASC. Such will be included within the overall demand/capacity modelling for long term P2 plans within LL

Appendix 7: Data to relating to Wd 22 LGH in UHL from Sept 22 to July 24, from system/UHL databases

Due to ongoing system challenges relating to the total number of medically optimised patients residing in University Hospitals of Leicester (UHL), in Sept 2022 UHL opened 16 beds on Wd 22 LGH to support flow for the Specialist Medicine (SM) CMG. Over time the bed base increased to 20 beds.

The 20 beds on Wd 22 LGH are managed by UHL internally for patients residing in SM CMG only. An internal referral process takes place whereby patients with P2 care needs showing rehabilitation potential are identified, and a request for internal transfer is made. Note: the Discharge Hub is not involved with this process.

UHL Therapists are aligned to the ward to support the rehabilitation approach and have a 5 day LOS to work with. In view of the need for flow and the 5 day LOS approach, 33% of patients who transfer to Wd 22 LGH are referred into the Discharge Hub for a system P2 IC/D2A bed predominantly within our community hospitals.

As per the data below, from the S1 DC Hub Unit, of 435 x P1-3 discharges from Wd 22 LGH between Sept 22 and July 24, 145 x patients were discharged to P2 IC/D2A system beds, and of which 108 x transferred to LPT for their IC/D2A journey. Also, 289 x patients' care needs converted from P2 to P1.

Count of Discharg Co	2022				2022 Total	2023												2023 Total	2024							2024 Total	Grand Total
Row Labels	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul		
1	**12**	**8**	**8**	**7**	**35**	**4**	**9**	**12**	**5**	**7**	**8**	**6**	**5**	**18**	**14**	**15**	**15**	**118**	**18**	**20**	**21**	**19**	**18**	**17**	**23**	**136**	**289**
N/A	12	8	8	7	35	4	9	12	5	7	8	6	5	18	14	15	15	118	18	20	21	19	18	17	23	136	289
2	**4**	**1**	**5**	**3**	**13**	**9**	**3**	**6**	**2**	**5**	**3**	**6**	**10**	**3**	**8**	**5**	**13**	**73**	**11**	**9**	**7**	**7**	**5**	**10**	**10**	**59**	**145**
COHO		1	4	2	7	5	1	3	1	4	3	3	8	2	6	4	12	52	8	9	7	7	4	6	8	49	108
HD	1				1							1	1					2	1							1	4
RH	1		1	1	3		1	1	1	1		2		1	2	1	1	11	1				1	4	2	8	22
TL/SOV	2				2	4	1	2					1					8	1							1	11
3																									**1**	**1**	**1**
NH																									1	1	1
Grand Total	**16**	**9**	**13**	**10**	**48**	**13**	**12**	**18**	**7**	**12**	**11**	**12**	**15**	**21**	**22**	**20**	**28**	**191**	**29**	**29**	**28**	**26**	**23**	**27**	**34**	**196**	**435**

Pathway	%	Comments
1	66	
2	33	28% went to P2 IC/D2A (CoHo and TL beds)
3	0	

In terms on P0 discharges from Wd 22 LGH, such data is not captured by the LLR Discharge Hub, therefore UHL provided the below data using NerveCentre. The data shows that of the patients who transferred between Jan 24 and July 24 to Wd 22 LGH with P2 care needs, 80 x patients' care needs converted from P2 to P0 (ave. 11 patients a month):

Count of Month of Discharge	Co							
Row Labels	Jan	Feb	Mar	Apr	May	Jun	Jul	Grand Total
0	8	13	10	10	12	15	12	80
Grand Total	8	13	10	10	12	15	12	80

Using extrapolation, the above data trend suggests that a further 165 patients were discharged via P0 from Wd 22 between Set 22 and Dec 23, instead of transferring from UHL to a P2 bed within the community.

Summary

Based upon the available system data over a two year period, it indicates that 534 x patients (ave. 267 a year) were supported on Wd 22 LGH, who would have otherwise required a P2 IC/D2A system bed. Such will be included within the overall demand/capacity modelling for long term P2 plans within LLR

Appendix 8: Options for Long-Term P2 Planning: for '24hr Residential Needs Cohort'

Please cross-reference the P2 Demand, Capacity, LOS, and Outcomes data (Aug 22 to July 24) when reviewing the below.

Option	Benefits	Quality and Equity	Risks	Mitigations	Current Yearly Financial Impact
A) Do nothing: **ASC continue to spot purchase Residential Care Home (RH) beds within the LLR Care Home Market without a system intermediate care (IC) offer, with or without standard LPT Community Therapy input via SPA**	- Through effective IDT face to face reviews of patients at ward level, and ASC panel review, there is assurance that the patients who transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - There is a plethora of privately run Residential Homes (RH) with residential care beds across LLR - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - Already CQC registered - Already staffed to provide and support all activities of daily living, and social care needs - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required	- The DC Hub and IDT do not have direct control of in and out flow, as the beds are privately owned and managed - Ave. 10 day wait for a P2 D2A RH bed via ASC (MOFD to actual discharge), increasing risk of deconditioning in hospital ***- Intermediate care (IC) is not provided in the RH beds, only D2A assessment, which results in poor long-term outcomes for our patients*** - Dependent on ward level referral to LPTs SPA, some patients receive standard Community Therapy input and others don't - Nationally 80% of patients who are discharged from hospital to RH beds without an intermediate care offer, never return to their own home and remain in long-term residential care; locally this is approx. 60% - Saturation of LLR Care Home beds - Self-funders having to use their life's savings to fund long-term RH beds, when they may have returned home with IC - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- ***The gap of 88 x system IC/D2A beds for this cohort would remain*** - Ave. 10 day wait for a P2 D2A RH bed via ASC (MOFD to actual discharge), impacting upon system flow - The RH Management Team have the final say about accepting patients, not the Discharge Hub/IDT - RHs often won't accept new patients at weekends, or beyond the afternoon - GP cover only. Risk of re-admission to the acute by the RH when a patient requires support with their health needs. Also, GP's don't register new patients at weekends and bank holidays - There are many RHs for ASC to cover, to provide effective case management and D2A assessment - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews - All County LA patients must be discussed at County ASC internal Fair Outcomes Panel prior to RH brokerage	- None: the quality concerns and risks relate to the RH's being privately run businesses, who: Do not provide IC Are spread across LLR Decide who/when to accept Rarely support weekend or bank hol admissions Prefer accepting long-term residents, not short-term Not 100% compliant with completing RH Tracker Rely on GP cover No system database for IC/D2A outcomes in RHs - Fair Outcomes Panel for County LA patients continues	These beds are financed through the system 'risk share' agreement until 31st March 25 **Cost Pre-Discharge from Acute Hospital** The proxy daily bed cost in the acute is £700. Therefore, the ave. yearly cost for LLR patients waiting 10 days in the acute for discharge to a spot purchased P2 D2A RH, is: £7000 per patient (per 10 days) X ave. yearly patient demand for UHL (1040 pt) = **£7,280, 000** **Cost During D2A Assessment Period** There are varying costs for RHs bed per week, but the ave. cost for both City and County, is: £875 bed/wk and £3500 bed/28days Based upon patient demand and a 28 day LOS in a RH bed, the ave. yearly cost for 'all LLR' residents requiring discharge to a RH bed via City (30%) and County (70%), is: City ave. = £1,232,000 (352 pt) County ave. = £2,863,000 (818 pt) Combined ave. = **£4,095,000** **Cost After D2A Assessment Period** On ave. 60% of LLR residents remain in long-term RH beds after D2A ax, and the ave. yearly cost to LLR, is: 466 pt a year x £44,200 ave. bed cost a yr (ave. £850 a wk) = £20,597,200 (exc. the approx. 43% self-funders in County) 271 pt a year x £46,072 ave. bed cost a year (ave. £886 a wk) = £12,485,512 (exc. the approx. 23% self-funders in City) Combined ave. cost = **£33,082,712** Note: approx. 10% more compared to D2A ax outcomes for pt discharged from Coalville Wd 4 **Total Ave. Yearly Cost to LLR** Prior to discharge: £7,280,000 During D2A ax: £4,095,000 After D2A ax: £33,082,712 **Total = £44,457,712**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
B) Procure 2 x 24hr carers in the patients' home, providing IC with the support of Community Therapy **Note:** the current system offer for P1 via ASC is a maximum of four calls a day with up to two carers (QDSx2), not 24hr carers	- Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who transfer do have 24hr residential care needs (not P1). However, this decision is based upon the current system/ASC offer of a maximum of four calls a day with up to 2 carers (not 24hr carers) - If 24hr care is precured, the IDT will continue to complete face to face reviews of patients to confirm level of need for discharge -Increase in P1 discharges, and vast decrease in P2 discharges	- ***The system IC/D2A bed gap could be met (with or without other option included)*** - The current ave. LOS for P1 discharges is 2 days, from 'MOFD to actual discharge'. However, depending on the offer available, the LOS may differ - Patients are supported in their own home ***- Both intermediate care 'and' D2A assessment would provided by health and social care partners in the patients home*** - Avoids saturation of LLR Care Home market beds - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- Data for eventual outcomes for this option does not exist within the system as it is not a historically commissioned service. Therefore, it is unclear what the impact could be for our residents - GP cover only. Risk of re-admission to the acute - ASC must align workers to all patients homes across LLR - Community Therapy must support all patients in their own homes across LLR; increased demand which will result in increased need for Therapists - There not being spare bedrooms for the carers to sleep in, so costlier waking night provision is required - Challenges with complying with Human Rights Act, and MCA Act and Deprivation of Liberty Safeguards, with 1:1 24hr care being restrictive - Challenges with brokering emergency step-up care in a RH to avoid hospital admission, should the patient not manage at home - Potential to destabilise LLR domiciliary care market - Managing expectation of patient and family when needing to reduce the POC, with 24hr care at home not a long-term offer via ASC - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews	Unable to mitigate the below due to: - predicting patient outcomes to evidence the patient benefits of this option - the need for MCA/DoLs due to legislation and law - waking nights must be brokered if a spare bedroom is not available - if the 24hr care does not meet need as planned, re-admission is likely as an emergency step-up bedded solution that meets overall demand is not yet planned or mobilised in LLR However, see possible mitigations below: -re-alignment of ASC workers - Monitor re-admission data - Community Therapy recruitment - IDT to work closely with patient and NOK to manage expectations re: reducing POC during the IC/D2A assessment - System to agree and mobilise a system database for these beds, or set-up and use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **High additional yearly cost to LLR, as the additional Community Therapy offer and 24hr carers would need be to be funded long-term**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
C) Mobilise Grace Dieu Ward in LPT long term, with an onsite intermediate care offer	- Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who would transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - ***Grace Dieu Ward*** is based in Loughborough Community Hospital and ***provides 19 x P2 IC/D2A beds.*** The site hosts four wards in total, offering peer support - The LPT MDT, Discharge Hub and IDT are familiar with providing a P2 IC/D2A offer within LPT's bedded settings; with success of patients returning home with P0 and P1 support - The system has experience with providing a P2 IC/D2A offer for the 24hr residential needs cohort on Coalville Wd 4, with success of patients returning home; the approach would be mirrored on Grace Dieu Ward - During winter 23/24 Grace Dieu Ward was hosted by UHL and supported by the Discharge Hub and IDT to provide a P2 IC/D2A offer for the 24hr residential needs cohort; with success of patients returning home - Transfers across 7 days, and no cut off time - County LA residents would not need to be discussed at County ASC internal Fair Outcomes Panel prior to transfer	- 24hr Nursing cover, Medical cover during working hours, and DHU cover during out of hours, to support patients' health needs and to avoid re-admission to the acute - ***Both intermediate care 'and' D2A assessment would be provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into a P2 CoHo bed is 2 days compared to 10 days for a RH bed, including the additional LOS due to incomplete transfer i.e. transport or TTO delay - Successful outcomes for patients receiving P2 IC/D2A support across LPT: approx. 85% return home, and 15% require long-term bedded care. Compared to approx. 60% requiring long-term bedded care from a P2 D2A RH in LLR - Data for discharge into and out of Grace Dieu Wd can be captured using the S1 DC Hub Unit and the S1 CoHo Unit - 'Reason to Reside' and 'Discharge by Pathway' shared with NHSE - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- ***The total of 19*** **x beds** would not meet the overall gap of 88 beds for this cohort, and ***leaves a gap of 69 x system IC/D2A beds for this cohort, so a further option would need to be mobilised*** - The ward is currently used as a decant ward for LPT, to support essential estates works i.e. as an established ward closes for works essential, it occupies Grace Dieu. Therefore, LPT would not have a decant ward if Grace Dieu opened long-term - The MDT and IDT must maintain a LOS of 28 days or less, to support system flow - The P2 IC/D2A offer is provided within a hospital environment, where hospital activities must still take place - Recruitment of additional Therapists to support this cohorts' needs	- Additional option to be chosen, signed-off, and mobilised to meet overall bed gap - LPT will need to close Community Hospital beds as vital estates works take place - Further engagement and training has been supported across LPTs Community Hospital teams (completed Oct 24), to embed both IC and D2A assessment within the 28 day LOS. - ASC will align workers to Grace Dieu Wd to ensure the D2A assessment is completed alongside the IC period within LPT, within the 28 day LOS. - the LPT MDT, alongside the IDT, will ensure patients are supported out of bed and dressed in their day clothes, they will promote the use of communal spaces and meaningful activities, and limit clinical intervention where possible/appropriate - Recruitment of Therapists	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **Moderate additional yearly cost to LLR, as the 19 beds do not form the total number of long-term funded beds within LPT**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
D) Limit or cease the number of sub-acute patients who transfer to LPT from UHL into a medical step-down bed (MSD), and instead re-model the beds to provide an onsite intermediate care offer for the 24hr residential needs cohort who are MOFD **Note:** the model would mirror that provided on Coalville Ward 4	- 34% of P2 CoHo beds are utilised for the MSD cohort - Data indicates that most MSD patients have P1 social care and health intervention needs that could instead be managed by Primary Care and Community Health Services and a POC at home, and therefore not need to transfer to a system P2 bed - Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who would transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - The LPT MDT, Discharge Hub and IDT are familiar with providing a P2 IC/D2A offer within LPT's bedded settings; with success of patients returning home with P0 and P1 support - The system has experience with providing a P2 IC/D2A offer for the 24hr residential needs cohort on Coalville Wd 4, with success of patients returning home; the approach would be mirrored across LPTs wards - Transfers across 7 days, and no cut off time - County LA residents would not need to be discussed at County ASC internal Fair Outcomes Panel prior to transfer - Opportunity to flex beds for the 24hr nursing cohort, should there be occasions where the demand outweighs capacity on Charnwood Ward	- ***This option would provide up to 70 x system P2 IC/D2A beds*** - 24hr Nursing cover, Medical cover during working hours, and DHU cover during out of hours, to support patients' health needs and to avoid re-admission to the acute - ***Both intermediate care 'and' D2A assessment would be provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into a P2 CoHo bed is 2 days compared to 10 days for a RH bed, including the additional LOS due to incomplete transfer i.e. transport or TTO delay - Successful outcomes for patients receiving P2 IC/D2A support across LPT: approx. 85% return home, and 15% require long-term bedded care. Compared to approx. 60% requiring long-term bedded care from a P2 D2A RH in LLR - Data for discharge into and out of LPT can be captured using the S1 DC Hub Unit and the S1 CoHo Unit - 'Reason to Reside' and 'Discharge by Pathway' shared with NHSE - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- ***The total of 70* x beds** would not meet the overall gap of 88 beds for this cohort, and ***leaves a gap of 18 x system IC/D2A beds for this cohort, so a further option would need to be mobilised*** - If the health intervention need is too high for Primary Care and Community Health Services to manage, medical step-down (MSD) patients may need to remain in the acute until health intervention complete, and instead be considered 'not MOFD' with 'a reason to reside' - The MDT and IDT must maintain a LOS of 28 days or less, to support system flow - The P2 IC/D2A offer is provided within a hospital environment, where hospital activities must still take place - Potential need to recruitment additional Therapists to support this cohorts' needs - Potential to destabilise LLR Care Home Market	- At this time, it is not possible to mitigate against the potential increased LOS in UHL should patients need to receive their remaining health intervention in the acute and not at home, as it is not yet known if Primary Care and Community Health Services have the capacity to meet the demand, or can respond within 24-48hr to support the P1 discharge - The 24hr residential needs cohort will no longer wait 10 days in UHL for a system P2 bed, but instead 2 days from 'MOFD to discharge', thus creating acute/system flow i.e. 8 less bed days for 1040 patients in UHL each year, resulting in a saving of 8,320 bed days per year. - Additionally, because most MSD patients have P1 needs not P2, they will be discharged with a POC via ASC within 2 days from being MOFD; this LOS being no different to the wait for a P2 bed in LPT for MSD, therefore not impacting on acute/system flow - Further engagement and training has been supported across all Community Hospital teams in LPT (completed Oct 24), to embed both IC and D2A assessment within the 28 day LOS. - ASC will align workers across all Community Hospital wards to ensure the D2A assessment is completed alongside the IC period within LPT, within the 28 day LOS (as they would no longer need to D2A assess patients in RH's) - the LPT MDT, alongside the IDT, will ensure patients are supported out of bed and dressed in their day clothes, they will promote the use of communal spaces and meaningful activities, and limit clinical intervention where possible/appropriate - Recruitment of Therapists	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **whilst there would be no additional cost to LLR for changing the operating model for the P2 beds hosted by LPT for the MSD cohort, there is anticipated moderate cost to the system to enable Primary Care and Community Health Services to instead provide the MSD cohort with their remaining health intervention at home (rather than within our P2 CoHo Beds or within UHL), which would need to be funded long-term**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
E) Procure 'RH beds and staffing' within existing privately run Residential Care Homes in LLR, and provide intermediate care with onsite support from ASC, Community Therapy and Community Care Home Training Team	- Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who would transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - There is a plethora of privately run Residential Homes (RH) with residential care beds across LLR - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - Already CQC registered - Already staffed to provide and support all activities of daily living, and social care needs - The system has experience with providing a P2 IC/D2A offer for the 24hr residential needs cohort - The system has prior experience of this option/model, when the system P2 Sovereign Unit and P2 Therapy Led Beds were in place - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required - County LA residents would not need to be discussed at County ASC internal Fair Outcomes Panel prior to transfer	- ***The system IC/D2A bed gap could be met (with or without another option included)*** - The DC Hub and IDT do not have direct control of in and out flow, as the beds are privately owned and managed ***- Both intermediate care 'and' D2A assessment would provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into a P2 Sov Unit or P2 TL Bed was 2 days when in place, compared to 10 days for a RH bed, including the additional LOS due to incomplete transfer i.e. transport or TTO delay - Based upon our IDT approach in our current P2 IC/D2A beds, there could be successful outcomes for our patients: across LPT approx. 85% return home, and 15% require long-term bedded care. Compared to approx. 60% requiring long-term bedded care from a P2 D2A RH in LLR - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- The RH Management Team have the final say about accepting patients, not the Discharge Hub/IDT, impacting on LOS from 'MOFD to actual discharge' - RH Managers often won't accept new patients at weekends, or beyond the afternoon - No nursing oversight for patients with complex care needs - GP cover only. Risk of re-admission to the acute by the RH when a patient requires support with their health needs. Also, GP's don't register new patients at weekends and bank holidays - ASC must align workers to all the Care Homes precured, in addition to all Community Hospital wards, and UHL wards to enable discharge planning - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews - Potential to destabilise LLR Care Home Market	- During the procurement/ contracts phase, to request that the beds are managed by the DC Hub and IDT, and the RH Management Team are informed about the transfer rather than be the final decision maker - During the procurement/ contracts phase, to request a 7 day approach to transfers so that beds can be utilised by the DC Hub and IDT during weekends and bank holidays - To fully utilise the beds by Friday, prior to the weekend - There will be fewer Care Homes for ASC to cover for D2A assessment, compared to spot purchasing P2 D2A RH beds across LLR without IC support - System to agree and mobilise a system database for these beds, or set-up and use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **Moderate additional cost to LLR, as the additional Community Therapy offer would need be to be funded long-term**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
F) Procure 'the building, beds and staffing' within a previously run private Residential Care Home in LLR, and provide intermediate care with onsite support by Nurses, Community Therapy, and ASC. The system will also need to run and maintain the estate, with the respective staffing resource	- Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who would transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - Empty and available care home settings available to purchase - The DC Hub and IDT have direct control of in and out flow, as the beds are system owned and managed (not beholden to Care Home market/managers): 7 days - The system can apply for CQC registration - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - The system has prior experience with providing a P2 IC/D2A offer for the 24hr residential needs cohort, within a system run bedded setting - Transfers across 7 days, and no cut off time - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required - County LA residents would not need to be discussed at County ASC internal Fair Outcomes Panel prior to transfer	- ***The system IC/D2A bed gap could be met (with or without other option included)*** - The DC Hub and IDT would have direct control of in and out flow, as the beds would be system owned - 24hr nursing oversight ***- Both intermediate care 'and' D2A assessment would provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into a system P2 bed is 2 days, compared to 10 days for a RH bed, including the additional LOS due to incomplete transfer i.e. transport or TTO delay - Based upon our IDT approach in our current P2 IC/D2A beds, there could be successful outcomes for our patients: across LPT approx. 85% return home, and 15% require long-term bedded care. Compared to approx. 60% requiring long-term bedded care from a P2 D2A RH in LLR - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- Sustaining the workforce for acute services within UHL, the workforce for Community Hospital/services within LPT, whilst also sustaining the workforce required for the Care Homes purchased - GP cover only. Risk of re-admission to the acute and GP's do not register new patients at weekends and bank holidays - ASC must align workers to all the Care Homes precured, in addition to all Community Hospital wards, and UHL wards - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews - Potential to destabilise LLR Care Home Market - Cost of maintaining the estate (see finance section re: running cost per bed)	- Recruitment of required workforce - To fully utilise the beds by Friday, prior to the weekend - There will be fewer Care Homes for ASC to cover for D2A assessment, compared to spot purchasing P2 D2A RH beds across LLR without IC support - System to agree and mobilise a system database for these beds, or set-up and use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **High additional yearly cost to LLR, as the additional estate and workforce would need to be funded long-term**

Appendix 9

The below is the patient criteria for the 15 x beds on Coalville Ward 4 in LPT, our system P2 IC/D2A bedded setting which operates to support the 24hr residential care needs cohort within LLR:

Coalville Ward 4 Patient Criteria

- The patient is a County or City Local Authority resident within LLR
  Note: not a Rutland LA resident
- Is an inpatient within hospital, who is medically optimised for discharge, and no longer meets the criteria to reside
- Upon discharge is unable to return home with health and social care or family support in the community i.e. currently unable to manage at home with a P1 care package and community health services
- Has 24h 'residential care' needs and requires a period of recovery, reablement and rehabilitation (intermediate care)
- Aim is for discharge home, after intermediate care and D2A assessment period to determine longer term care needs

24hr Residential Care Needs include:

- May or may not have cognitive impairment (acute and/or chronic)
- May or may not be confused (acute and/or chronic)
- Care needs can range from all care in bed with A02, to A01 with care needs as the patient is relatively able with ADL's but their cognitive impairment is the limiting factor to safety at home without 24hr supervision
- May or may not need support with hydration and nutrition
- May or may not be incontinent (urine and/or faeces)
- Mobility may range from Ao2 with hoist, to Ao1 with frame or supervision
- Wandering with or without purpose. There may be a risk of absconding
- May display altered behaviours: shouting, distress, crying, verbal aggression
- IP may include: MRSA, CRO, and covid etc

Note: if the patient's altered behaviours relate to physical aggression and 1:1 support is in place for such, the patient should be reviewed for the High Dependency Cohort and should 'not' transfer to Coalville Wd 4

Exclusion – patients who meet the following criteria:

- Rutland LA residents
- Patients for P1 discharge
- 24hr Nursing Needs Cohort
- 24hr High Dependency Cohort
- Temporary Health Conditions Cohort (aka NWB)
- CHC Fast Track discharge from the acute (EoL)
- Acquired Brain Injury Pathway

Location of P2 D2A/IC bed: Coalville Community Hospital, Coalville Wd 4, LPT

- All LLR patients who meet the criteria can transfer to Coalville Ward 4; including LLR patients in OOA Trusts who reside in a LLR Local Authority and registered with an LLR or OOA GP

Appendix 10: Options for Long-Term P2 Planning: for '24hr High Dependency Needs Cohort'

Please cross-reference the P2 Demand, Capacity, LOS, and Outcomes data (Aug 22 to July 24) when reviewing the below.

Option	Benefits	Quality and Equity	Risks	Mitigations	Finance
Continue to contract and commission High Dependency Beds in a Dual Registered Care Home, *with onsite Community Therapy*, as the IC/D2A offer for the 24hr high dependency needs cohort **Note:** the alternative being to return to discharging patients to P2 Care Home beds without an IC offer, with the support of MLCSU	- Through effective IDT face to face reviews of patients at ward level, there is assurance that the patients who transfer do have 24hr high dependency care needs (not P1) - There is a plethora of privately run Dual Registered Carel Homes (CH) across LLR - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - Already CQC registered - Already staffed to provide and support all activities of daily living, and social care needs - 1:1 provided onsite, as required - The system has experience with providing a P2 IC/D2A offer/model for the 24hr high dependency needs within Everdale Grange CH - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required	- ***The system IC/D2A demand can be met*** - The DC Hub and IDT do not have direct control of in and out flow, as the beds are privately owned and managed - 24hr nursing oversight as needed **Note:** compared to spot purchasing separate RH and NH beds without IC - GP cover ***- Both intermediate care 'and' D2A assessment would provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into this bed type is 6 days, including the additional LOS due to incomplete transfer i.e. transport or TTO delay **Note:** compared to approx. 6wks (42 days) when brokering spot purchased P2 RH/NH beds without IC - Based upon our IDT approach in our current P2 IC/D2A beds, the outcomes for our patients are: 74% long-term bed, 13% home, 12% readmission, and 1% RIP **Note:** historic data for HD cohort specifically is not available - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- The RH Management Team have the final say about accepting patients, not the Discharge Hub/IDT, impacting on LOS from 'MOFD to actual discharge' - RH Managers often won't accept new patients at weekends, or beyond the afternoon - GP cover only. Risk of re-admission to the acute by the CH when a patient requires support with their health needs. Also, GP's don't register new patients at weekends and bank holidays - ASC must align workers to all the Care Homes precured, in addition to all Community Hospital wards, and UHL wards supporting P3 decision making, to enact D2A assessment - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews	- During the procurement/ contracts phase, to request that the beds are managed by the DC Hub and IDT, and the RH Management Team are informed about the transfer rather than be the final decision maker - During the procurement/ contracts phase, to request a 7 day approach to transfers so that beds can be utilised by the DC Hub and IDT during weekends and bank holidays - To fully utilise the beds by Friday, prior to the weekend - There will be fewer Care Homes for ASC to cover for D2A assessment **Note:** compared to spot purchasing P2 D2A RH and NH beds across LLR without IC support - System to agree and mobilise a system database for these beds, or continue to use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **No additional cost to LLR as the beds are already financed by until 30th June 25, but agreement and sign-off is required for long-term funding**

Appendix 11: Options for Long-Term P2 Planning: for '24hr Nursing Needs Cohort'

Please cross-reference the P2 Demand, Capacity, LOS, and Outcomes data (Aug 22 to July 24) when reviewing the below.

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
Continue to commission Charnwood Wd in LPT as the IC/D2A offer for the 24hr nursing needs cohort **Note**: the alternative being to return to discharging patients to P2 D2A NH beds without an IC offer, with the support of MLCSU	- Through effective IDT face to face reviews of patients at ward level, there is assurance that the patients who transfer do have 24hr nursing needs (not P1) - There is just one site for the IDT to work within for this cohort **Note:** not several NHs across LLR - The patients are supported and progressed by the LPT workforce and the LLR IDT, with a focus on both IC and D2A assessment - Overall case management is not required by MLCSU as an additional funded service **Note:** patients only receive D2A assessment in P2 D2A NH beds, not IC - Since Oct 23 when Charnwood Wd was mobilised for 24hr nursing cohort, the system has provided the P2 IC/D2A offer through this bed base/model with success **Note:** better patient outcomes compared to the P2 D2A NH bed approach - Data for discharge into and out of Grace Dieu Wd can be captured using the S1 DC Hub Unit and the S1 CoHo Unit **Note:** no system database in place for patients supported in P2 D2A NH beds	- ***The system IC/D2A bed gap can be met if three additional beds are mobilised in LPT*** - The DC Hub and IDT has direct control of in and out flow, as the beds are managed by system **Note:** we are not beholden to the care home market ***- Intermediate care 'and' D2A assessment are provided by the MDT and IDT*** - 24hr nursing oversight, Medical cover during day, and DHU out of hours - The ave. 'LOS from MOFD to actual discharge' into these P2 beds is 7 days, including the additional LOS due to incomplete transfer i.e. transport or TTO delay **Note:** compared to 11 days for a P2 D2A NH bed - Based upon our IDT approach in the P2 IC/D2A beds, there are successful outcomes for our patients: approx. 15% return home, and 42% require long-term bedded care. **Note:** compared to approx. 60 % requiring long-term bedded care from a P2 D2A NH bed in LLR - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- The MDT and IDT must maintain a LOS of 28 days or less, to support system flow - The P2 IC/D2A offer is provided within a hospital environment, where hospital activities must still take place	- ASC have aligned workers to Charnwood Wd to ensure the D2A assessment is completed alongside the IC period within LPT, within the 28 day LOS. - The LPT MDT, alongside the IDT, ensure patients are supported out of bed and dressed in their day clothes, they promote the use of communal spaces and meaningful activities, and limit clinical intervention where possible/appropriate	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **No additional cost to LLR, as the beds are already funded within LPT long-term**

Appendix 12: Options for Long-Term P2 Planning: for '24hr Bariatric Needs Cohort'

Please cross-reference the P2 Demand, Capacity, LOS, and Outcomes data (Aug 22 to July 24) when reviewing the below.

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
Continue to contract and commission Bariatric Therapy Led Beds in Residential Homes as the IC/D2A offer for the 24hr bariatric needs cohort **Note:** the alternative being to return to discharging patients to P2 CoHo beds in LPT, resulting in two bed spaces per patient	- Through effective IDT face to face reviews of patients at ward level, there is assurance that the patients who transfer do have 24hr bariatric care needs (not P1) - Just two care homes for the IDT to visit and work within **Note:** not several care home and the Community Hospitals - Bed base supports patients with either health or social care needs (RH and NH beds) - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - Already CQC registered - Already staffed to provide and support all activities of daily living, and social care needs - The system has experience with providing the P2 IC/D2A offer through this bedbase/model **Note:** Avoids the need to utilise 2 x bed spaces in LPT for each patient - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required	- ***The system IC/D2A bed gap could be met*** ***(with or without other option included)*** - The DC Hub and IDT do not have direct control of in and out flow, as the beds are privately owned and managed - 24hr nursing oversight, as required - GP cover ***- Intermediate care 'and' D2A assessment are provided by the MDT and IDT*** **Note:** in P2 D2A RH beds they don't - The ave. 'LOS from MOFD to actual discharge' into these P2 beds is 5 days, including additional LOS due to delayed discharge i.e. TTO **Note**: compared to 10 days for a RH bed, or 5 days to a P2 CoHo bed - Based upon our IDT approach in the P2 IC/D2A beds, there are successful outcomes for our patients: approx. 65% return home, and 16% require long-term bedded care. **Note:** compared to approx. 60% requiring long-term bedded care from a P2 D2A RH bed in LLR - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- The RH Management Team have the final say about accepting patients, not the Discharge Hub/IDT, impacting on LOS from 'MOFD to actual discharge' - RH Managers often won't accept new patients at weekends, or beyond the afternoon - GP cover only. Risk of re-admission to the acute by the RH when a patient requires support with their health needs. Also, GP's don't register new patients at weekends and bank holidays - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews	- During the procurement/ contracts phase, to request that the beds are managed by the DC Hub and IDT, and the RH Management Team are informed about the transfer rather than be the final decision maker - During the procurement/ contracts phase, to request a 7 day approach to transfers so that beds can be utilised by the DC Hub and IDT during weekends and bank holidays - To fully utilise the beds by Friday, prior to the weekend - System to agree and mobilise a system database for these beds, or set-up and use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **No additional cost to LLR, as the beds are already financed through the ICB's Discharge grant until 31st March 25, but agreement and sign-off is required for long-term funding**

Appendix 13 Data re: patients with medical-step down needs who transferred from UHL into P2 Community Hospital beds, using the S1 DC Hub Unit and S1 CoHo Unit

Review of UHL to LPT Transfers for P2 CoHo Medical Step-down Cohort (MSD)

For patients who transferred to LPT from UHL for P2 CoHo medical step-down beds (MSD) between June to Sept 24, a review took place of the RDS' submitted into the Discharge Hub identifying the patients' health and social care needs. Additionally, an internal review by LPT also took place of the patients' onward care, medical intervention, and discharge plans whilst residing in LPT; which indicated that for some patients, their MSD needs were above what had been described on the referral form.

The below shows the themes for the medical-step down support required for the patients, and the possible alternative plan for discharge from UHL (rather than to a P2 bed), based upon the patients' social care need upon arrival in LPT, should Primary Care and Community Health Services be able to provide the medical-step down intervention outside of the hospital setting. However, there is need for a system led review to take place of LLR Primary Care and Community Health Services to confirm if it would be possible for medical-step down patients to be discharged home from the acute instead of to system P2 beds:

Theme for Medical Step Down	Count
Blood test and monitoring	1
Breathlessness	1
Cellulitis. Pain management	1
Constipation. Pain management	2
Constipation: laxatives	2
CXR in 6-8wks	1
Hydration and nutrition	1
Hypokalaemia. Pain management	1
Hypotension. Pain management.	1
IV antibiotics. Pain Management.	3
IV Antibiotics. Pain management.	1
IV antibiotics. Pain management. Constipation and laxatives. Wound clip	1
IV antibiotics. Pain management. Constipation and laxatives. Wound clip	1
IV antibiotics. Wound clip removal in 2	2
IV Meds. Pain management. Wound clip	1
IVAB. Pain management	1
IVI. Oxygen ween. Hydration	1
Monitor CBGs	1
NIV care support/rehab	1
Oral Antibiotics	1
Oral antibiotics. Hypotension. Medication	1
Oral antibiotics. Pain management	2
Oxygen ween	3
Pain management	15
Pain management. Constipation.	1
Pain management. Constipation:	1
Pain management. Hydration	1
Pain management. Wound clip removal	3
Pain managment	1
Resolving delirium but orientated	2
Treatment for AKI. Pain management	2
Treatment for high CBG. Pain	1
Treatment for UTI. Pain management.	1
VAC and wound management	1
Grand Total	**60**

Potential Alternative Plan to P2 Discharge From	Count	%
None: Acute Care Required	8	13
P0	1	2
P0 and Community Support	1	2
P1 and Community Support	35	58
P1 and Community Support after O2 ween	2	3
P1 and Community Support with OPAT	5	8
P1 and Community Support. VAC insitu	1	2
P1 via THC Pathway	1	2
P2 Appropriate as 24hr social care needs	5	8
P2 via THC Pathway	1	2
Grand Total	**60**	**100%**

Of the patients reviewed, the below shows the reason/pathway for the onward discharge from LPT after the patients had received their medical-step down intervention and rehab in the Community Hospital setting; such correlates with the potential alternative plan for discharge directly from UHL (rather than to a P2 bed) should Primary Care and Community Health Services be able to provide the medical-step down intervention outside of the hospital setting:

	Count	%
P0	8	13
P1	38	63
P1 THC	1	2
P2 THC RH	1	2
P3 RH	4	6
Re-admitted to UHL within 1 day	2	3
Re-admitted to UHL within 2 day	3	5
Re-admitted to UHL within 13 days	1	2
Re-admitted to UHL within 26 days	1	2
Re-admitted to UHL within 7 days	1	2
Grand Total	60	100%

Note: the average LOS for MSD patients supported in LPT for both their medical-step down and rehab is 20 days

In terms of the current ave. LOS from MOFD to actual discharge from UHL to a P2 CoHo bed, please see below:

Average of LOS: MOFD to DC	Column Labels																											
	2022						2023																		2024							
Row Labels	Aug	Sep	Oct	Nov	Dec	2022 Total	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 Total	Jan	Feb	Mar	Apr	May	Jun	2024 Total	Grand Total
LPT	2	2	2	2	3	2	2	3	2	2	2	2	1	1	2	3	3	3	2	4	3	2	2	2	2	3	2
2	2	2	2	2	3	2	2	3	2	2	2	2	1	1	2	3	3	3	2	4	3	2	2	2	2	3	2
Grand Total	2	2	2	2	3	2	2	3	2	2	2	2	1	1	2	3	3	3	2	4	3	2	2	2	2	3	2

Whilst this is not an exhaustive review of all patients who transferred from UHL to LPT into a P2 CoHo/MSD bed during June to Sept 24, and the data doesn't cover many months or even years, it does indicate that P2 beds are being utilised for patients with P0 and P1 social care needs, as our P2 Community Hospital bedded setting is currently modelled to support the medical-step down cohort. Therefore, there is the potential for such beds to be re-modelled to support the P2 24hr residential needs cohort instead, and the MSD instead be discharged home from the acute with a Pathway 1 package of care at home, with support from Primary Care and Community Health Services.

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As previously mentioned, the ave. LOS from 'MOFD to actual discharge' for discharge to a P2 CoHo bed is 2 days, whereas the LOS from 'MOFD to actual discharge' for the 24hr residential needs cohort waiting for discharge to a standard P2 D2A Rh bed is 10 days. Therefore, there is potential for saving many beds days in the acute each year.

Average of LOS: MOFD to DC	Column Labels																											
	2022						2023																		2024							
Row Labels	Aug	Sep	Oct	Nov	Dec	2022 Total	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 Total	Jan	Feb	Mar	Apr	May	Jun	2024 Total	Grand Total
City	7	6	6	5	4	6	4	5	4	6	5	5	5	4	5	3	3	3	4	3	3	3	5	4	4	4	4
1	6	4	4	4	4	4	4	3	3	3	4	4	4	3	2	2	2	3	3	2	2	2	3	3	3	3	3
2	10	12	11	10	8	10	7	14	12	15	11	14	11	11	14	9	10	8	11	10	8	8	10	8	7	9	10
3			8	46	24	22	7	5		16	11	19	16	4			19	5	13	5	16	10	11	17	18	13	13
County	6	8	6	6	4	6	4	5	4	4	4	3	3	4	4	6	5	5	4	4	4	3	4	4	4	4	4
1	5	5	4	4	3	4	3	4	3	3	2	2	2	2	3	4	3	3	3	3	3	3	3	2	3	3	3
2	11	15	12	13	12	13	8	11	8	9	10	7	8	11	11	15	13	10	10	10	10	8	9	8	12	10	11
3	4	10	21	19	3	14	6	30	14	48	15	11	28	19	27	3	7	28	19	7	11	14	18	16	14	14	15
Grand Total	6	7	6	6	4	6	4	5	4	5	5	4	4	4	4	5	4	4	4	3	4	3	4	4	4	4	4

Based on available LOS and demand data, the potential bed days saved for UHL by ceasing transfer of the medical-step down cohort and instead using the beds for MOFD with 24hr residential care needs, is below:

- Ave. yearly demand of the 24hr residential needs cohort in UHL is: 1040 x patients
- The ave. time waiting in UHL for a P2 D2A RH bed for the above cohort, from 'MOFD to actual discharge', is 10 days
- The ave. time waiting for a P2 CoHo bed for a MOFD patient in UHL, from 'MOFD to actual discharge', is 2 days
-

Therefore, acknowledging the data/intel above, the below bed savings could be made across one year:

- 1040 x patients waiting 10 days whilst MOFD is 10,400 bed days a year
- 1040 x patients waiting 2 days whilst MOFD is 2,080 bed days a year
- 10 day cohort – 2 days cohort = *8,320 bed days saved a year*

Summary

- Data indicates that, based upon current system agreed bed modelling for our Community Hospitals, P2 CoHo beds are being utilised for the medical-step down cohort with P1 social care needs. Note: the ongoing medical intervention is what drives the need for step-down into the P2 bed, to create and support system flow
- There is potential for the system P2 CoHo beds being utilised for patients with P1 care needs, to instead be used for patients with P2 24hr residential care needs; supporting the reduction in the system P2 IC/D2A bed gap for this cohort
- However, there is need for a system led review to take place of LLR Primary Care and Community Health Services to confirm if it would be possible for medical-step down patients to be discharged home from the acute instead of to system P2 beds, to release P2 IC/D2A capacity for patients with 24hr residential care needs

Discharge Grants 2024-2025

Review Template

Scheme Name	Housing Enablement Team
Discharge Grant funding allocation for 2024-25	**£165,760**
Service area (e.g., Community services etc.)	Hospital Discharge
Service Lead & Contact Details	Shanice Senghor – shanice.senghor@blaby.gov.uk - **07825256481**
ICB Service Lead & Contact Details	
Geographical Place coverage (e.g. City, County, Rutland or LLR)	Leicester, Leicestershire and Rutland
Service Provider/s (e.g. In-house or sub-contracted) If sub-contracted please provide a copy of the sub-contract this funding contributes to.	Blaby District Council act as host for the Housing Enablement Service

Scheme Description **Including:** • What is the key purpose of the scheme? • What additionality has this funding enabled beyond standard service delivery?	**Background:** The Housing Enablement Service began as a pilot in 2014 in the Bradgate Mental Health Unit. The success of the initial pilot led to a sister pilot in the UHL hospital covering the LRI, Glenfield and General Hospital. In 2016 the two pilots were merged into a single service with a single management structure. Increased success has since led to further pilot expansions of the service into the MH Rehab sites at Stewart House and the Willows, the MHSOP wards in the Bennion Centre and Evington Centre and into all the Community Hospitals in Leicester and Leicestershire. The key focus in 2014 was to radically redesign housing support and create an integrated housing offer for clinical care settings. The service is focused on delivering health and wellbeing outcomes for patients and to alleviate housing related barriers to discharge. HET has also pick up additional work regarding complex cases that no other service is designed to take. For example, there have been several cases whereby patients with No Recourse to Public Funds have been in hospital with Tuberculosis and HET have created and supported a discharge pathway. Since 2015, the Housing Enablement service has benefited from a dedicated partnership team who have worked intensively with stakeholders to break down barriers to change, co-produce solutions, and challenge the system, across a very complex (national and local) policy landscape for health and care. **The Key Purpose of the HET Service is to:** • Ensure patients are discharged from hospital in a timely manner to a safe place or their usual place of residence • Help prevent delayed transfers of care **The service aims to do this by providing:** • An access point into a range of practical housing support solutions within hospitals - Continually improving the customer journey; making services easier to access and navigate and ensuring the right discharge solution is available at the right time with the right outcome. • A common, holistic housing needs assessment process - Provide efficient, cost-effective service delivery through service redesign; capitalising on opportunities to create more effective

	working practices, and improved processes to create more timely and appropriate solutions to aid hospital discharges. • A broader, targeted offer of practical housing support - Providing a pragmatic response to a wide range of complex issues that contribute to an extended length of stay and/or a delayed discharge in various care settings. • Sole responsibility for fulfilling the DTR legal obligation placed on public bodies. In January 2023, The Housing Enablement Service brought forward a business case to request funding from 1st April 2023 to 31st March 2026 from the Integrated Care Boards (ICBs) in Leicester City and Leicestershire County and the Leicestershire Partnership Trust (LPT). **The additional discharge funding allowed the service to:** • Recruit an additional support officer post in UHL needed to support increased demand. • Increase funding for interventions to allow HET to cope with the increased demand across all sites, provide quicker interventions and enable more discharge solutions. • Cover BDC overhead costs not factored into the previous contract and allow BDC to continue hosting the service. • The addition of a new service manager post to strategically support the service and the wider LLR system in relation to housing discharge support and involvement in complex discharge cases. • Fully operate without a waiting list - UHL Hospitals (LRI, Glenfield and Leicester General) All Community Hospitals in Leicester and Leicestershire Bradgate Mental Health Unit MH Rehab Sites (Stewart House and The Willows), Bennion Centre and Evington Centre (MHSOP), George Elliot Hospital (Leicestershire Patients only) • Recruitment of a triage officer role to support the volume of referrals and provide real time updates to clinical staff. The funding has enabled the service to continue to keep up with demand and patients are continuing to benefit from prompt query resolutions which wouldn't be offered without extra staffing

	resources. Partners across the health and care system, (who have already seen the dramatic impact of the housing discharge enabler service), can have confidence that measurable system wide benefits are generated when housing support is fully embedded in health and care pathways. The funding has also allowed the service is committed to continuous improvement and redesign to fit with changing NHS priorities and service delivery.

Quantitative and Qualitative Evidence of Impact and Benefits, Outcomes and Outputs for

- Service Users and
- The System

The HET service is skilled in working with often the most vulnerable and complex patients including those with mental health conditions, multiple long-term conditions, the homeless, victims of domestic abuse and those with no recourse to public funds. A key to its success is the pragmatic response required to help patients, families and carers navigate complex pathways. The service not only provides housing solutions but also benefits advice, residency documentation and access to foodbanks. In addition to this staff work in the community with patients once they are discharged to support them particularly when accessing longer-term housing solutions for example in the private rented sector.

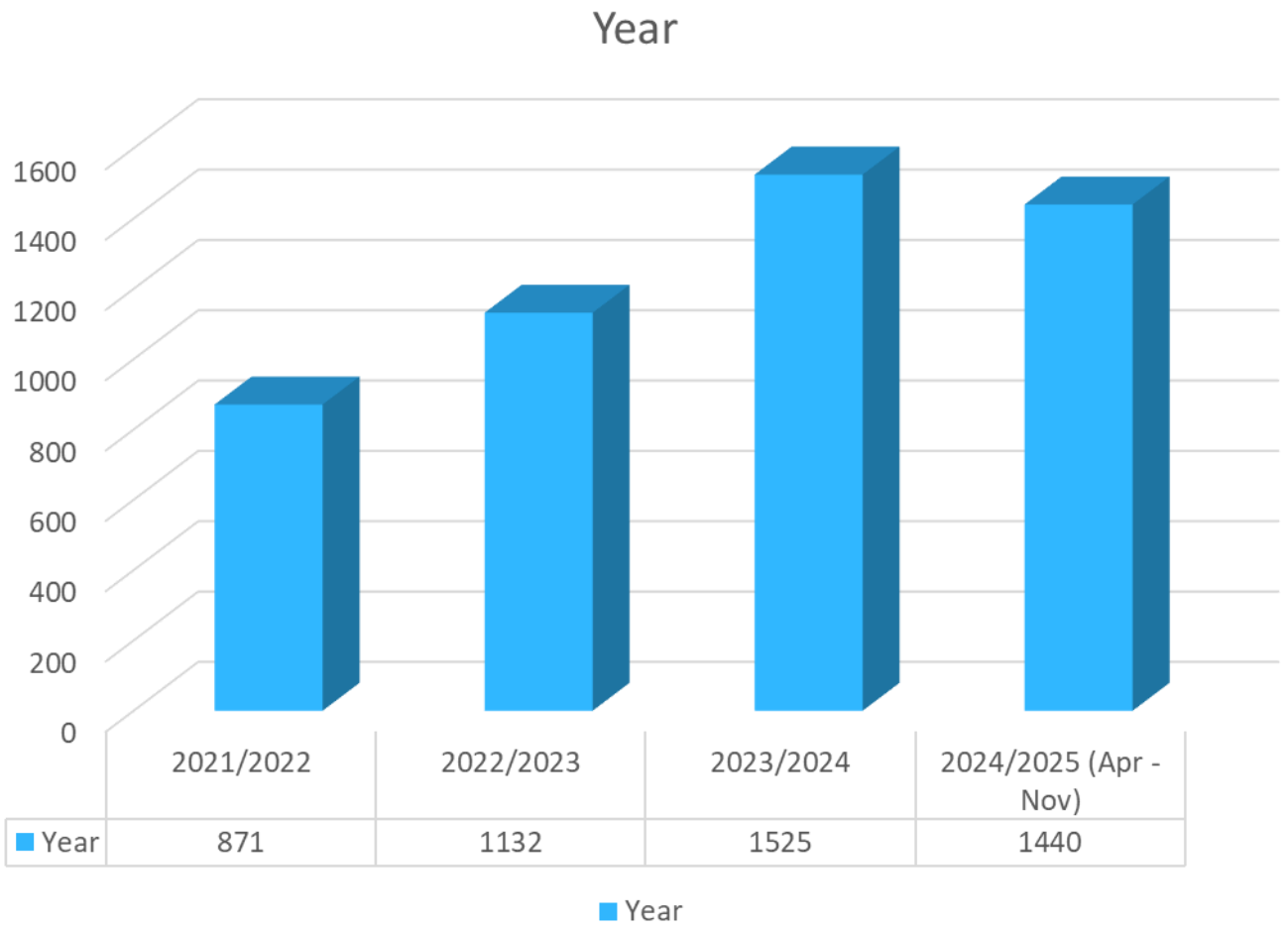
The evidence that good-quality housing is critical to health is well established (Public Health England 2017). A well-housed population helps to reduce and delay demand for NHS services and allow patients to go home when they are clinically fit to do so. It is estimated that the cost of poor housing to the NHS is £1.4 billion per year (BRE 2015)1 . So, it is clearly in the interests of the NHS and local authorities, to work more closely with housing partners as STPs develop to reduce demand on acute services and local authority services.

The HET service has a direct benefit for the LLR System as outlined below:

With HET's Business Critical Service	Without HET Disparate Service Offer
Improved DTOC rates – Increases potential to meet national DTOC targets	**Housing related enquiries have to be completed by clinical /social care staff –** detracting from patient care including duty to refer for homeless patients.
Reduce re-admissions – Due to instigating longer term housing solutions (e.g. warm homes, clean and clear, access to the private rented sector)	**Increasing residential care placements –** Where patients unable to live independently at home

Reduces Health Inequalities – Improving outcomes for vulnerable and marginalised patients	**Uncoordinated non-clinical discharge activity –** Potentially resulting in DTOC and increased length of stay
System Integrators – The bridge between clinical care and community services.	**DTOC delays –** Increase due to a lack of coordination around housing and other non-clinical/social related issues
Outcomes – 22 different outcomes linked to a network of partners offering a pragmatic response across numerous agencies including district councils, Home Office, voluntary sector	**Increased readmissions –** Due to no / poor housing provision
System Connectivity – Linked to a network of other partners – action homeless, foodbanks, furniture packs, clean and clear & voluntary sector	I**ncreased length of stay –** whilst housing issues are resolved
Demand Management – Demand has continuously increased in BMHU and UHL, with data showing that for UHL in particular, total annual referrals for 2022/2023 were surpassed in just 6 months in 2023/2024.	**Housing service becomes a lottery depending on your care setting**
Continuity of Service – Irrespective of care setting	**No system or recognised process for the most vulnerable –** (e.g. homeless, dependent)
Early Identification of Housing and community service Needs – Optimises flow through hospital	**Hospital Flow –** Bottlenecks of patients with complex discharge needs decreasing hospital flow

	HET also provides return on investment by reducing healthcare costs associated with delayed discharge, emergency readmissions and reduced A&E attendances. Since the last business case in 2018 HET's intervention has seen: • A fall in housing related emergency admissions up to 70% • Housing related A&E attendances a reduction of 56% • There is a 50% rise in 'no activity' (no further services required across health, social care and community) from 40 service users prior to Housing Enabler intervention to 80 service users post intervention. (Across 30 days) The NHS constitution 'Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. HET's integrated approach to housing support directly aligns with this vision and will support the model of future service delivery; helping to ensure people can get the right level and type of support at the right time to help prevent, delay or reduce the need for ongoing support and maximise their independence. This funding has allowed HET to be able to accept more referrals and there has been a significant increase in demand this has been created by HET integrating further into the system. **Volume of Service Users Benefiting from the service:**



As the HET service has grown, demand on the service has also grown. From the point at which the last contractual agreement was signed, there have been three principal areas where demand on the HET service has significantly increased:

	Expansion in further sites therefore needed for staff resource Increase in referral numbers Increase in clean and clear cases to support discharge home As well as an increase in the sites covered and an increase in referrals, HET as also picked up additional duties that were not factored into the initial funding contract. For example, in recent years there have been several patients with TB that needed long-term treatment in the community, unable to be discharged from hospital because they had no address to go to and could not access statutory homelessness services because of their status in the UK. In order to prevent these patients becoming lengthy delays in vital IDU beds, HET agreed to secure accommodation for these patients and manage them in the community so that they could receive continual treatment outside of hospital. There is no additional funding provided for the demand on staff member's time for the management of these cases, which has put significant strain on HET as ordinarily, HET is an inpatient only service. HET also pick up Duty to Refer (DTR) cases. DTRs is a specific legal duty placed on Hospital Trusts, requiring them to refer patients that are either homeless or threatened with homelessness to Local Housing Authorities. HET satisfies this duty on behalf of UHL and LPT in all cases that are referred to HET. The HET Team Leader is also assisting in working with UHL and LPT to review and rewrite their discharge policies in relation to this duty. Without HET, this duty would fall on clinical staff to do, taking away vital time they could be spending with patients. HET staff are also experts in homelessness, so are able to ensure that DTRs are handled efficiently within the letter of the law. The vital service that HET provides was not factored into the last funding agreement and needs to be considered now so that HET can ensure we have the correct number of appropriately trained staff to manage this additional workload. Service user satisfaction is exceptionally high, with 97% of feedback being positive. Patients have expressed significant appreciation for the team's effective communication, with many stating they were kept well-informed throughout the process and felt reassured by the team's responsiveness. Service Users expressed feedback during a recent survey: *Service User 1*

"The Housing Enablement Team really helped me get discharged from the hospital quickly. They communicated directly with my landlord to extend my notice period, which gave me more time to sort things out and prepare for the move. I felt supported every step of the way, and it made a big difference in ensuring I didn't have to stay longer in the hospital. I really appreciate their help in making the whole process smoother."

Service User 2
"The team saved my life. I was so relieved when Claire said my home could be cleared so I could return after my hospital stay. I was overwhelmed and depressed. The Housing Enablement Team were told by the ambulance team that my home was a mess, they arranged everything I needed so I wouldn't have to deal with the stress of cleaning and sorting things out myself. They made sure my home was ready for me, and that allowed me to focus on my recovery instead of worrying about anything else. It was a huge weight off my shoulders. I am forever grateful"

Summary –

The Housing Enablement Team has proven to be a transformative service, significantly reducing delayed transfers of care (DTOC), decreasing costs, and improving patient outcomes. By addressing housing-related barriers, the HET has saved the NHS approximately **over £1.1 million** through reduced out-of-area bed costs and prevented readmissions for chronic homeless patients. The service also ensures smoother transitions for patients, reducing bed stays by up to an average of **7 days per patient**. while delivering essential long-term housing solutions for over **62% of homeless patients**. Losing funding for the HET would reverse these achievements, leading to prolonged hospital stays, higher healthcare costs, and diminished quality of life for vulnerable patients. Without the HET, the system would face increased pressures, risking a return to inefficient pathways and substantial financial and human costs.

Key Facts

	✓ Provides patients with longer term sustainable housing solutions to reduce the burden on acute care ✓ Reduces housing related discharge delays and length of stay in care settings ✓ Reduces the burden on health and social care staff in dealing with complex service user needs, freeing up capacity within the system for other aspects of patient care ✓ Provides return on investment by reducing healthcare costs associated with DTOC's, emergency readmissions and reduced A&E attendances ✓ Reduces residential care placements by supporting patients to live independently at home. ✓ Provides a proactive, integrated and pragmatic response with immediate availability to small amounts of funding to cover costs associated with speeding up discharge

Any other data collected and reported and how often Please attach data and case studies to support this review.	**<u>UHL Long-Term Tuberculosis Treatment Case</u>** Mr C was a 21-year-old gentleman originally from Vietnam. He was believed to possibly be the victim of trafficking as he reported being taken first to China at age 5 and then the UK at age 15. He has never had any documentation and has never been known to Children's services. At age 18 he was left alone and then spent the next few years living with various acquaintances and working cash-in-hand jobs. He came to the attention of the HET service when he was admitted into the LRI with Tuberculosis (TB). Due to his diagnosis, he could not return to his previous acquaintance's property as they did not want him back whilst having TB, leaving Mr C homeless on the ward with no rights in the UK. It seemed that Mr C would become a long delay in the ward as he needed consistent TB treatment for a minimum of 12 months. However, with the support of the CCG, HET was able to source accommodation for Mr C to be discharged to, where he would be safe and could receive continual TB treatment in the community. The HET Support Officer has provided ongoing practical support to Mr C for the length of his stay in the accommodation, such as supporting him with shopping and other tasks. HET also referred Mr C to the British Red Cross for support with an Asylum claim. This allowed Mr C to be supported to leave hospital safely, ensuring there is some long-term plan for Mr C's housing and welfare and reducing the need for a lengthy hospital admission, saving public money and reducing the demand on important hospital beds. **<u>Community Hospitals Case</u>** Mr D was a 55-year-old gentleman admitted into one of the Community Hospitals in LLR. On admission, he was living in a social housing property. Mr D was known to mental health services and physical health services due to ongoing issues with recurrent depressive disorder and OCD, as well as ongoing investigations regarding bowl irregularities. Concerns were expressed by ward staff and the medical team that the patient would be unable to be discharged home because his flat was very unkempt and cluttered, leaving no room for him to mobilise. There were also signs of mouse excrement. HET received consent from Mr D to visit the property along with his sister and social worker. The HET Support Officer assessed the property and took photos of the flat, which confirmed the condition of the property and the work/support needed to make discharge safe. The HET Support Officer then had the property quoted and facilitated the work to be carried, cleaning and clearing the property so it was safe for Mr D to be discharged. This action allowed for a prompt discharge from hospital for Mr D and meant that he could receive ongoing care in his own home.

	MHSOP Case Mr G is a 69-year-old gentleman and a UK citizen. Prior to his admission into hospital, he was living in an 11th floor flat in the city centre. He suffers from hoarding issues and also had an infestation of bed bugs. He was admitted into hospital suffering from poor mental health and suicidal tendencies. The OT determined that his home was affecting his mental health as he previously had a partner who had committed suicide and was found within Mr G's flat. The OT's asked for him to be placed in another form of accommodation and were not happy to discharge back to the previous flat. Mr G gave permission for HET to visit the property and carry out an assessment. Upon assessment it was determined his home was in disrepair, infested and hoarded. HET asked Mr G if he would be happy to move location if we could support this into sheltered accommodation , which he agreed to do. HET then sourced an immediately available property through our partnerships with local housing associations ; this was a ground floor self-contained one bedroom unit within a new area to give Mr G a fresh start. HET supported the application process, viewing and successful sign up. HET also supported the move of any items Mr G wanted to keep with two Housing Support Officers helping him with this process. This enabled Mr G to be discharged from hospital into a new environment which would prevent him from needing to be readmitted. **UHL Adults Case** Mr B was a 74-year-old gentleman and a UK citizen. On admission to hospital, he was living in a social housing property in Charnwood. Mr B was admitted with a hip fracture as the result of a fall in his property and also had COPD. His fall was caused by the poor condition of his property and Mr B suffers with hoarding issues. Mr B gave the HET permission to visit his property to take photos, which showed clear signs of hoarding and suggested that Mr B had been unable to care for the property for some time due to his other health issues. HET were able to arrange a clean and clearance of the property to make it safe for Mr B to be discharged to with a package of care. The Safe Spaces team were also able to offer on-going support for Mr B's hoarding issues to ensure that did not negatively impact on his health in the future. This intervention allowed Mr B to return home, rather than go into care, which he did not want to do and allowed a safe discharge back into the community that otherwise would have resulted in a lengthy hospital admission and costly residential care placement.

Could the scheme continue to operate with a lower level of annual funding than at present? What impact would a level of reduced ICB funding have for the System and Service users? Please describe any risks/issues you are aware of if we continue to fund the scheme and how these are being mitigated? **Quanative & Qualtative impact Speciaqlly**	If HET were to receive less funding, the impact would be felt deeply across both the healthcare system and the vulnerable individuals it supports. While the service might continue to operate, its ability to meet the growing demand for housing support and deliver timely solutions would be severely limited. With reduced funding, HET would be forced to handle fewer referrals and possibly need to create a waiting list and the team would have less capacity to address housing-related delays. This would mean more patients would experience **longer hospital stays**, particularly those with complex housing needs, such as people with mental health issues or chronic homelessness. Delays in discharge would increase, causing more **bed-blocking** in hospitals and longer waiting times for patients needing ongoing care. This would not only lead to a **strain on bed pressures** but also escalate the costs of care, as patients would be in hospital longer than necessary. The healthcare system would be under more pressure, and the reduction in timely housing support would likely result in **higher readmission rates**, as patients would face difficulties transitioning back to their homes or stable accommodation. For patients, losing funding would mean fewer options for securing the **housing support** they need to recover. People facing homelessness, in particular, would be at a higher risk of being discharged to unsafe or unsuitable accommodation, leaving the trust at risk. Without HET's help, patients may struggle to find permanent housing, face delays in obtaining **home clearance's or furniture**, and could be left in temporary, inadequate conditions that exacerbate their health issues. For those with mental health challenges, it would mean **more stress, instability, and uncertainty**, which could lead to a decline in their condition and a higher chance of **re-admission to hospital**. **Vulnerable patients** who are discharged into poor housing conditions would have limited access to follow-up support, resulting in longer-term negative effects on their mental and physical health. In short, a reduction in funding would make it much harder for HET to provide the support that many of the most vulnerable patients rely on. The **knock-on effects** would be felt not only in the form of increased hospital admissions and prolonged stays but also in the day-to-day lives of individuals who, without stable housing, would continue to struggle to recover and rebuild their lives.

Risk/Issue	Description	Mitigation
Increasing Demand for Services	Growing demand for housing support services, potentially leading to an overstretched team and delayed housing solutions for patients.	Streamlining workflows, prioritizing urgent cases, exploring partnerships with local authorities and community organizations, and providing on-going staff training to manage higher volumes more efficiently.
Sustainability of Staffing	Insufficient staffing to meet the growing complexity of housing-related issues, and uncertainty due to reliance on external funding.	Seeking additional funding sources, integrating services with broader community programs, increasing team cross-functional expertise to handle a wider range of cases without additional personnel.
Continuity of Service in a Changing Landscape	Potential disruptions in housing availability due to changes in housing policy or priorities.	Strengthening relationships with local authorities and housing associations, engaging in housing policy discussions to ensure adaptability, and creating reliable, diverse housing pathways for patients.
Financial Constraints and Rising Costs	The risk of funding cuts or reduced scope of services due to financial pressure from local government or NHS budget cuts.	Demonstrating the value of HET through data collection, highlighting cost savings, and focusing on patient outcomes to secure long-term, sustainable funding from multiple sources.
Impact of Staff Burnout	Increased risk of staff burnout or stress, particularly with rising demand and tight funding, leading to turnover and reduced service quality.	Investing in staff well-being through regular debriefings, team support networks, mental health resources, and workforce planning to ensure adequate staffing while fostering a positive work environment to retain skilled professionals.

Outline risks and impact if Discharge Grant funding does not continue in 2025-26	If the Discharge Grant funding does not continue in 2025-26, the following risks and impacts could arise: • **Disruption to Service Continuity**: **Risk**: The cessation of funding could lead to a disruption of services currently provided and other discharge-related support functions. **Impact**: This may result in delays in patient discharge, affecting the hospital flow and potentially increasing the length of stay (LOS) for patients who would otherwise be discharged faster with housing-related support. • **Increase in Delayed Transfers of Care (DTOC)**: **Risk**: Without the grant funding, housing-related DTOCs could rise significantly, particularly for patients with complex housing needs, including the homeless or those requiring supported accommodation. **Impact**: Hospitals may see a rise in bed blockages, impacting hospital capacity and patient throughput. This could worsen already stretched NHS resources and prolong waiting times for other patients requiring acute care. • **Increased Pressure on Other Services**: **Risk**: The loss of the grant may place additional strain on other services, such as adult social care, local authorities, and homelessness services, who may not be equipped to take on the demand. **Impact**: The reliance on already overburdened services would likely lead to delays in resolving housing-related issues, resulting in a backlog of cases and potentially poorer outcomes for vulnerable patients. • **Negative Impact on Service Users**: **Risk**: Patients, particularly those with mental health issues, chronic homelessness, or housing instability, could face worsening living conditions or a return to homelessness. **Impact**: The lack of support would exacerbate physical and mental health conditions for patients who may be discharged without suitable housing, leading to a potential deterioration in their well-being. • **Deterioration of Patient Outcomes**:

	Risk: Without the discharge grant funding, the wraparound services that prevent homelessness and facilitate smooth transitions from hospital to community care could be severely reduced or stopped. **Impact**: This could lead to poorer long-term health outcomes for patients, including higher rates of mental health crises, relapse, and ultimately, the need for further healthcare interventions. • **Loss of Stakeholder Confidence**: **Risk**: The absence of funding might lead to dissatisfaction among patients, healthcare providers, local authorities, and other stakeholders involved in discharge planning. **Impact**: This could damage trust in the local health and social care system, potentially affecting partnerships and collaboration on future projects and initiatives. Without continued funding, the healthcare system could face operational challenges, including rising hospital costs, and service users could experience negative health outcomes due to inadequate housing support after discharge. It is essential to explore alternative funding solutions and strengthen cross-department collaboration to mitigate these risks.
Have alternative funding streams been scoped for this area of work.	Alternative funding streams for the service have been explored, but the Grants Officer at Blaby District Council has been unable to identify any viable sources to replace the Discharge Grant funding. Despite efforts to find alternative funding this has proven difficult. Housing and healthcare funding streams are often separate.

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DRAFT: Equality Delivery System (EDS): Intermediate Care Services Grading Report March 2025

Purpose of the report

The ICB is required to engage with the system providers to identify 3 services per annum to be subject to the equality delivery System (EDS) grading. This would be based on three services which fall into one of these categories:

- There is best equality practice and outcomes
- There is little or no improvement in equality practice and
- Where there is little known as no equality monitoring is identified

For 2024/5 Three services were identified for EDS grading:

- Chaplaincy Services
- **Intermediate Care (Discharge Pathway 1)**
- Perinatal Mental Health services

This report sets out the results of the Intermediate Care EDS grading exercise. It includes the grading result and suggested improvement actions for the service to consider. The results will contribute to the systems overall rating (and that of the ICB) combined with Domains two and three grading and will also help towards any CQC inspections as part of their 'Well Led Domain' assessment.

Engagement and Grading Exercise

The two proposed grading workshops were advertised through comms & engagement teams from the Local Authority and ICB. The stakeholders invited were representative of the protected groups, socio-economic demographic groups/communities and other people living locally. Unfortunately, only one person turned up at the first workshop on 25th February who agreed to attend the second session instead (which was readvertised).

Five people attended the second grading workshop on 27th February; however, participants wanted more time to reflect and score. Subsequently, the deadline was extended by two weeks and followed up with a reminder to respond a week later. We received feedback and scores from five people (one more that the Maternity Diabetes workshop held the year previously). Despite the low attendance the evidence collected has been invaluable

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around the protected groups and received very positive feedback from peers. This will be used for future planning ahead.

What is Intermediate Home Care Service?

Intermediate care (Step down, also referred to as intermediate care beds or high-dependency beds, are one possible approach to providing higher levels of care while improving the efficiency of patient flow.) It involves community-based assessments and interventions provided to people in their own home:

- Home-based; Discharge Pathway One,
- Short-term community bedded settings; bed-based discharge pathway two.

Home-based intermediate care is the default pathway as per the 'home first' approach (a person's home is their usual place of residence). Someone may be discharged from bed-based to home-based intermediate care to continue their intermediate care. For most people in acute hospitals, a simple discharge home without the need for step-down intermediate care is the most appropriate pathway (discharge pathway 0).

Intermediate care services can be entirely health care, entirely social care, or ideally have elements of both delivered by multi-disciplinary teams working in integrated ways.

Intermediate care focuses on step-down– time-limited, short-term (typically no longer than 6 weeks) health and/or social care provided to adults (aged 18 years or over) who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover.

Expected Outcomes

Implementation of step-down intermediate care is expected to result in improved outcomes, experiences and independence of people discharged, reduced avoidable hospital readmissions, and reduced avoidable/premature long term care provision. Further expected benefits include improved flow and discharge from acute and community hospitals, freeing-up NHS hospital capacity for those who need it most.

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LLR – Data

- Pathway 1 data comprises of discharges from both UHL hospital & Community hospital beds to home (discharged home with a new or increased Package of Care (POC).
- Data analysed P1 hospital discharges to home with a new or increased package of care (data analysed from LLR discharge hub data pack).
- Pathway 1 Discharge Data diagnostic period was from 1st October 23 to 31st September 2024.
- Pathway 1 comprised of 3702 service users and 4406 instances.
- Average length of stay was 3 days for all service users between 1st October to 31st September 2024.

UHL-Data

- 3425 patients (58%) on pathway 1c from a total of 5866 instances.
- Data taken from Sept 2023 to Sept 2024
- Overall average LOS was 15.87 days

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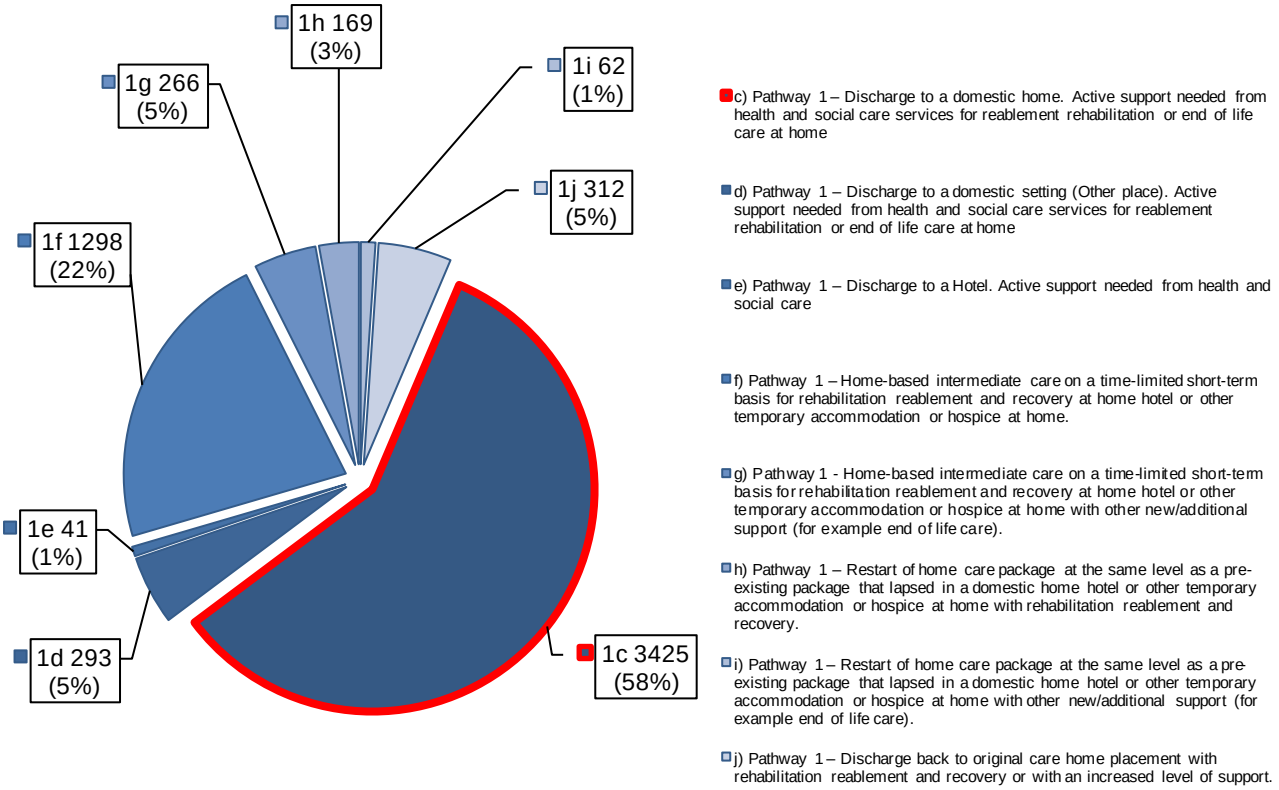


Outcome 1A Patients (service users) have required levels of access to the service

KEY *LOS = Length of stay

Data and evidence demonstrate that those with higher risk due to protected characteristics or at risk of inequalities have adequate access, patients report to receiving a good level of care and accessibility to the service. Accessibility to intermediate care is an equal rights service which hasn't demonstrated any form of discrimination for those patients from protected characteristics. The service is provided as and when required and to those that require it.

The following data provides a patient overview:

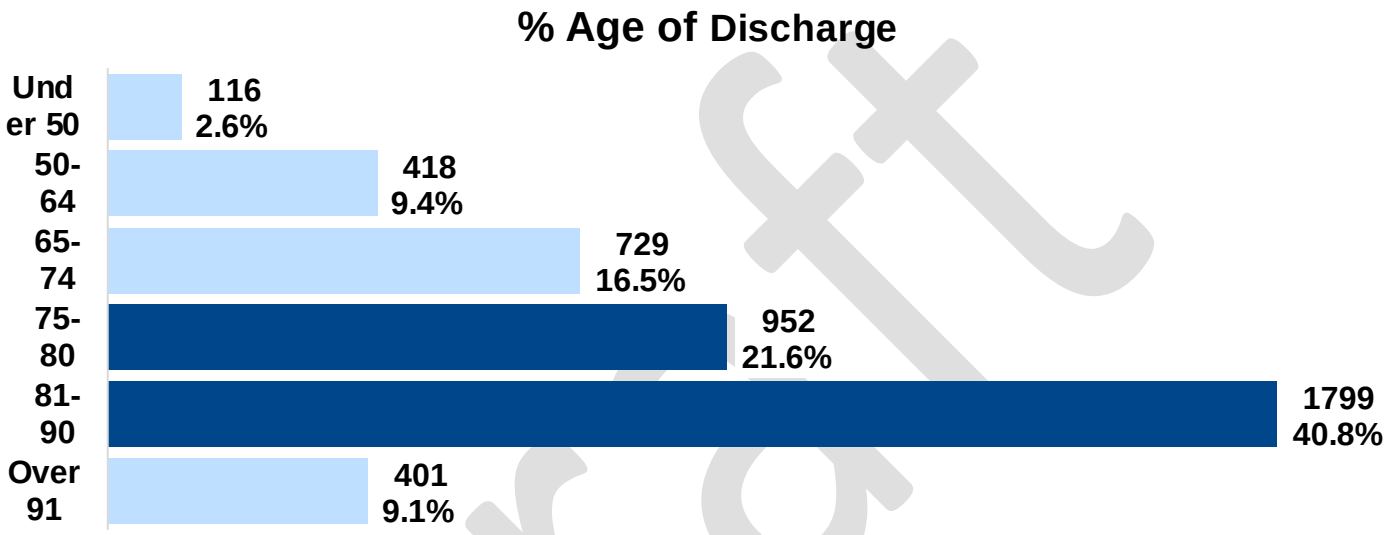
LLR

- Pathway 1 LLR data comprised 3742 patients with 4406 discharge instances (15% of patients were re-admissions across this data review period)
- 56% of discharged patients were female and 44% male
- 83.5% of patients discharged were from non-minority ethnic groups
- 16.5% of patients discharged were from a minority ethnic group.

UHL

- Pathway 1c data compromised of 3425 patients
- Protected characteristics suggest a significant impact on Length of stay (LOS)
- Number of discharges for some characteristics unlike what was expected in relation to area population data

LLR Demographics



- Most of our service users are between 65-103 years of age (88%), this is very much aligned with frailty and the growing aging population.
- 12% of the service users were under 64.

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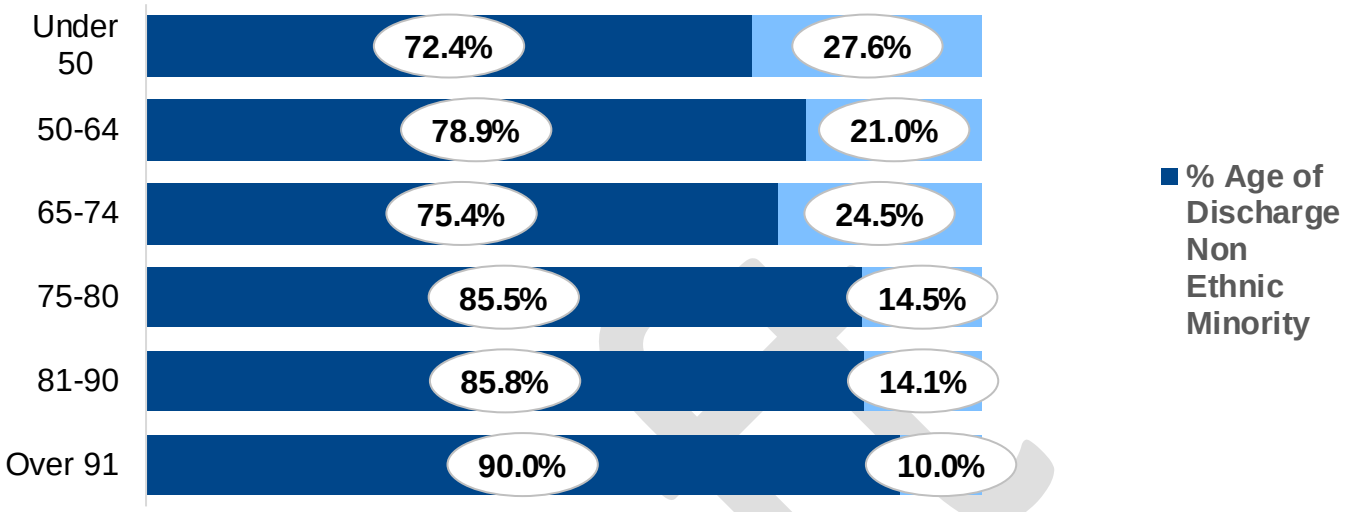
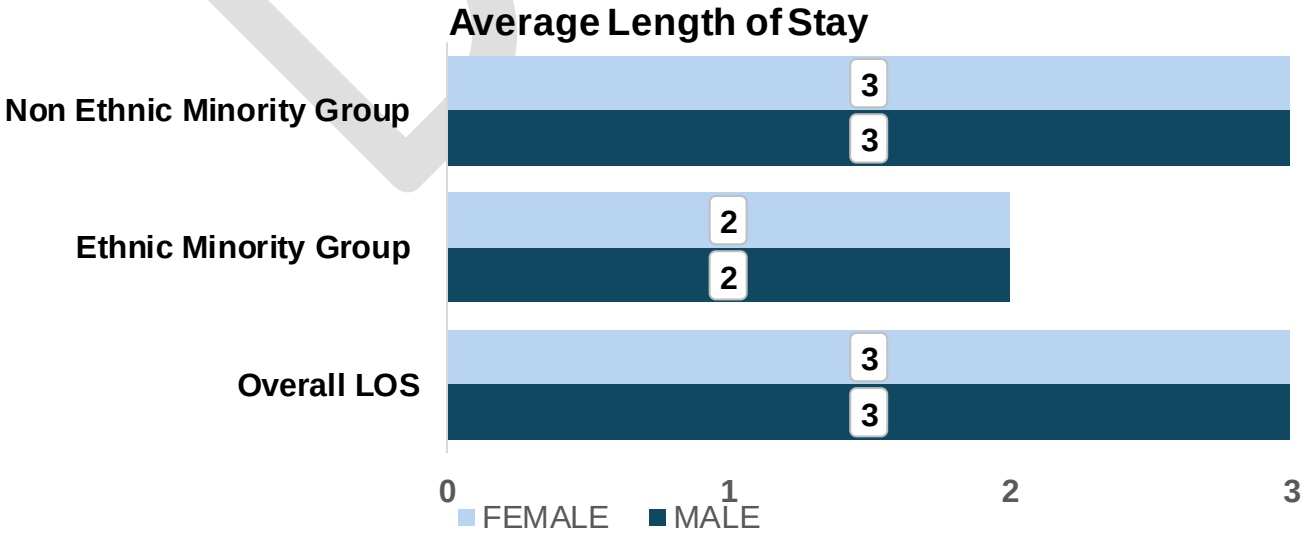
% Discharge Age proportionate Minority Ethnic V Non-Minority Ethnic group



The above data demonstrates the demand between different age groups alongside ethnic and non-ethnic minorities that have accessed the intermediate care service across diagnostic period.

- Accessibility to service and the length of stay – averages across all patients was 3 days during the diagnostic period.
- Both the male and female population split from non-ethnic minority had an average of 3 days length of stay.
- Those from a minority ethnic groups' average length of stay of 2 days both for Male and Female.



KEY *LOS = Length of stay

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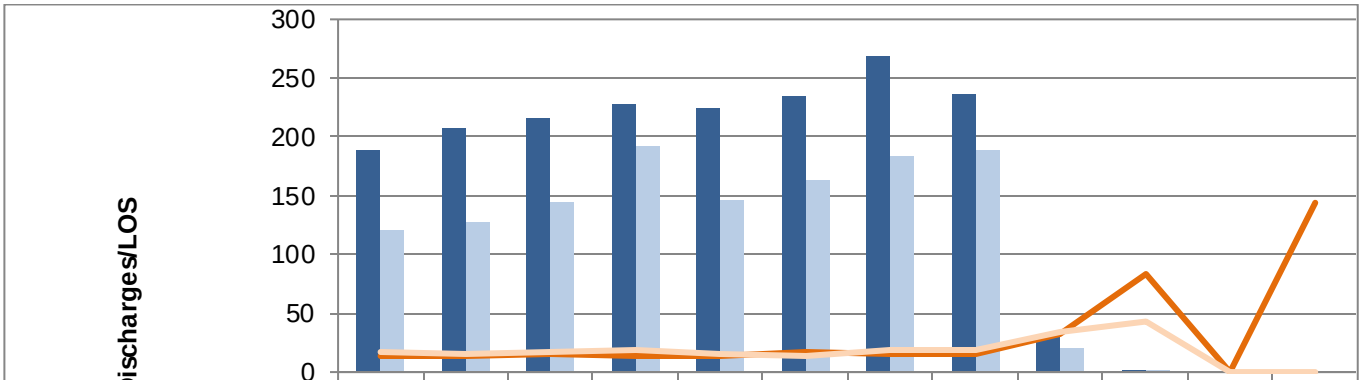
UHL Demographics

Monthly Average LOS and number of Discharges by sex



	31/10/2023	30/11/2023	31/12/2023	31/01/2024	29/02/2024	31/03/2024	30/04/2024	31/05/2024	30/06/2024	31/07/2024	31/08/2024	30/09/2024
Female Discharges	189	207	216	228	224	234	269	236	30	2	0	1
Male Discharges	121	128	144	192	147	163	183	189	20	2	0	0
Average LOS (F)	13.3	14.1	15.1	12.9	14.3	17.6	15.3	15.8	31.6	83	0	144
Average LOS (M)	16.4	15.2	17.1	18.1	16.2	14.2	18.1	18	34.4	43	0	0

- Total discharges: Female 1836 (58.8%) Male 1289 (41.2%)
- Average LOS: Female 31.4 (14.8 for months with 100+ discharges) Male 17.6 (16.6 for months with 100+ discharges)

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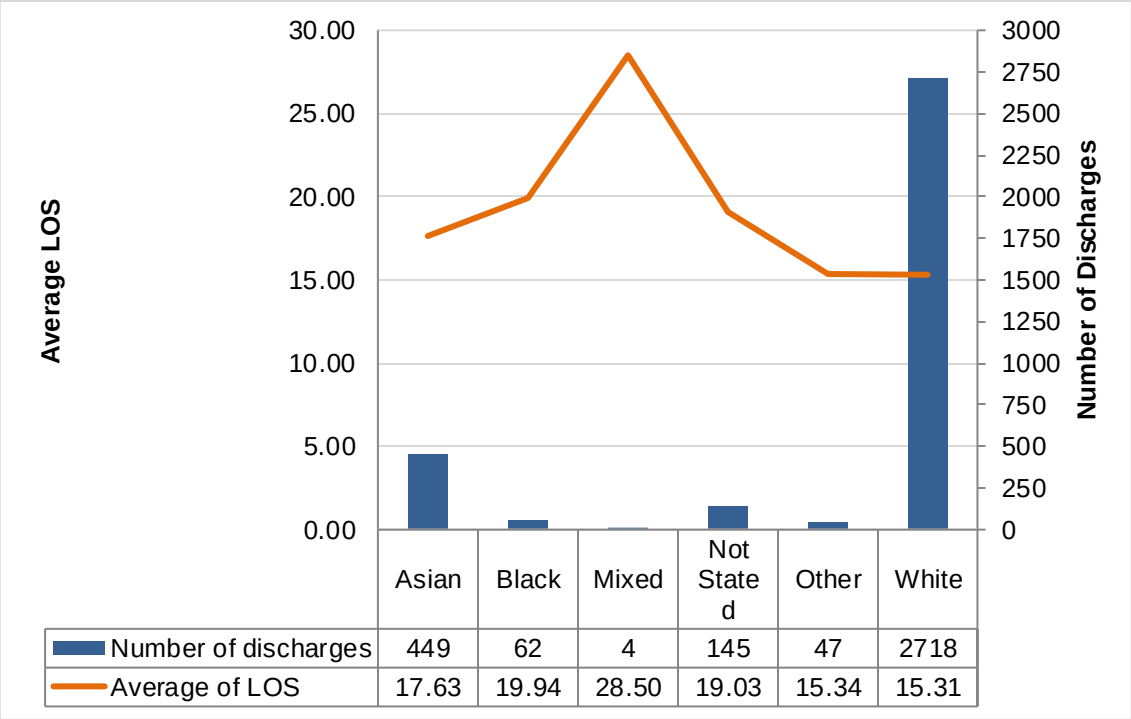
Average LOS and Number of Discharges by Ethnicity



	Asian	Black	Mixed	Not Stated	Other	White
Number of discharges	449	62	4	145	47	2718
Average of LOS	17.63	19.94	28.50	19.03	15.34	15.31

Please note:
'Asian' includes patients who identify as the following: Asian/Asian Brit Bangladeshi, Asian/Asian British Indian, Asian/Asian British Pakistani, Any Other Asian Background.
'Black' includes patients who identify as the following: Black/Black British African, Black/Black British Caribbean, Any Other Black Background
'Mixed' includes patients who identify as the following: Mixed White & Black Caribbean, Any Other Mixed Background
'White' includes patients who identify as the following: White British, White Irish, White Other White Background

- 79.3% of discharged patients identify as 'White' compared to 74.6% of population according to 2021 census
- 13.1% of discharged patients identify as 'Asian' compared to 17.6% of population according to 2021 census
- 1.8% of discharged patients identify as 'Black compared to 1.8% of population according to 2021 census
- 0.1% of discharged patients identify as 'Mixed' compared to 4.6% of population according to 2021 census

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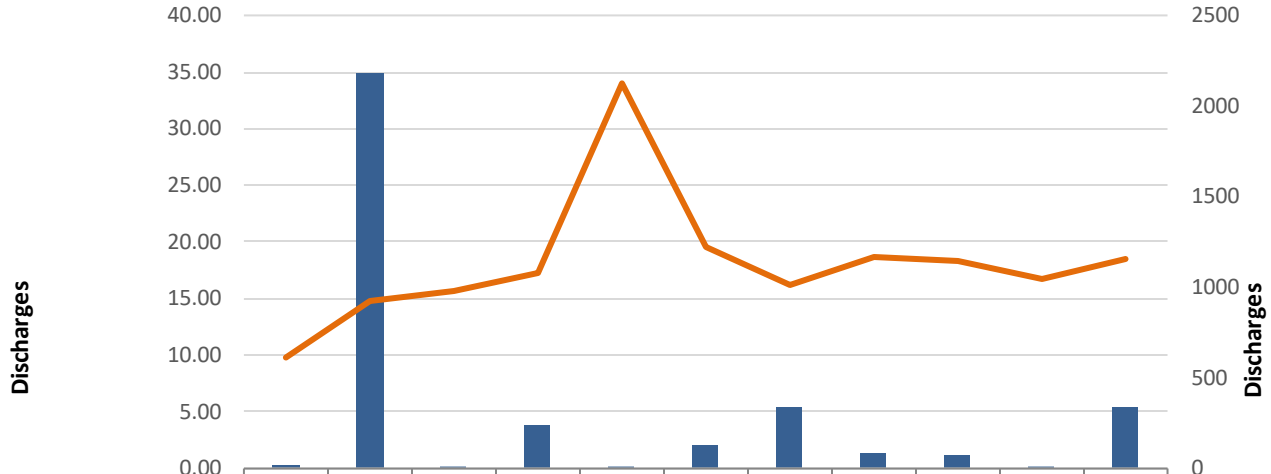
Average LOS and number of Discharges by Religion



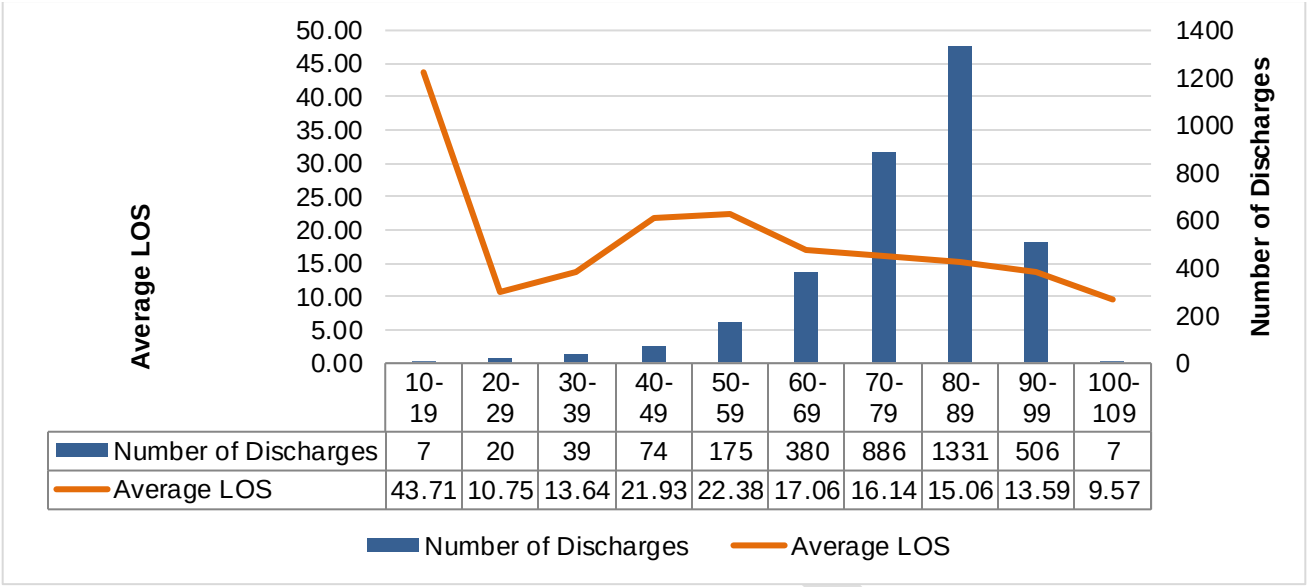
	Buddhism	Christianity	Eastern Orthodox	Hinduism	Judaism	Muslim	Non-Theistic	Other	Sikhism	Spiritualism	Unknown
Number of discharges	15	2180	3	244	1	135	340	82	71	10	344
Average of LOS	9.80	14.87	15.67	17.32	34.00	19.62	16.13	18.66	18.24	16.80	18.54

Please note:

- 'Buddhism' includes patients who identify as the following: Buddhist, Jain, New Kadamba Buddhist
- 'Christianity' includes patients who identify as the following: 7th Day Adventist, Anglican, Baptist, Calvinist, Catholic (Not Roman), Christadelphian, Christian, Church of England, Church of Ireland, Church of Scotland, Congregationalist, Evangelist Christian, Free Church, Jehovah's Witness, Latter Day Saints, Methodist, Mormon, Orthodox Christian, Pentecostalist, Plymouth Brethren, Protestant, Presbyterian, Quaker, Reformed Christian, Roman Catholic, Salvation Army Member, Unitarian, United Reform
- 'Eastern Orthodox' includes patients who identify as the following: Greek Orthodox, Romanian Orthodox, Serbian Orthodox
- 'Hinduism' includes patients who identify as the following: Hindu
- 'Judaism' includes patients who identify as the following: Jewish
- 'Muslim' includes patients who identify as the following: Baha'i, Islamic, Ismaili Muslim, Muslim
- 'Non-Theistic' includes patients who identify as the following: Agnostic, Atheist, Humanist, None
- 'Other' includes patients who identify as the following: Other
- 'Sikhism' includes patients who identify as the following: Sikh
- 'Spiritualism' includes patients who identify as the following: Druid, Pagan, Spiritualist, Wiccan
- 'Unknown' includes patients who identify as the following: Unknown, Religion Withheld

- 63.6% of discharged patients identify as 'Christian' compared to 25% of population according to 2021 census
- 3.9% of discharged patients identify as 'Muslim' compared to 23% of population according to 2021 census
- 7.1% of discharged patients identify as 'Hindu' compared to 18% of population according to 2021 census
- 2.1% of discharged patients identify as 'Sikh' compared to 4% of population according to 2021 census
- 9.9% of discharged patients identify as 'non-theistic' compared to 23% of population according to 2021 census

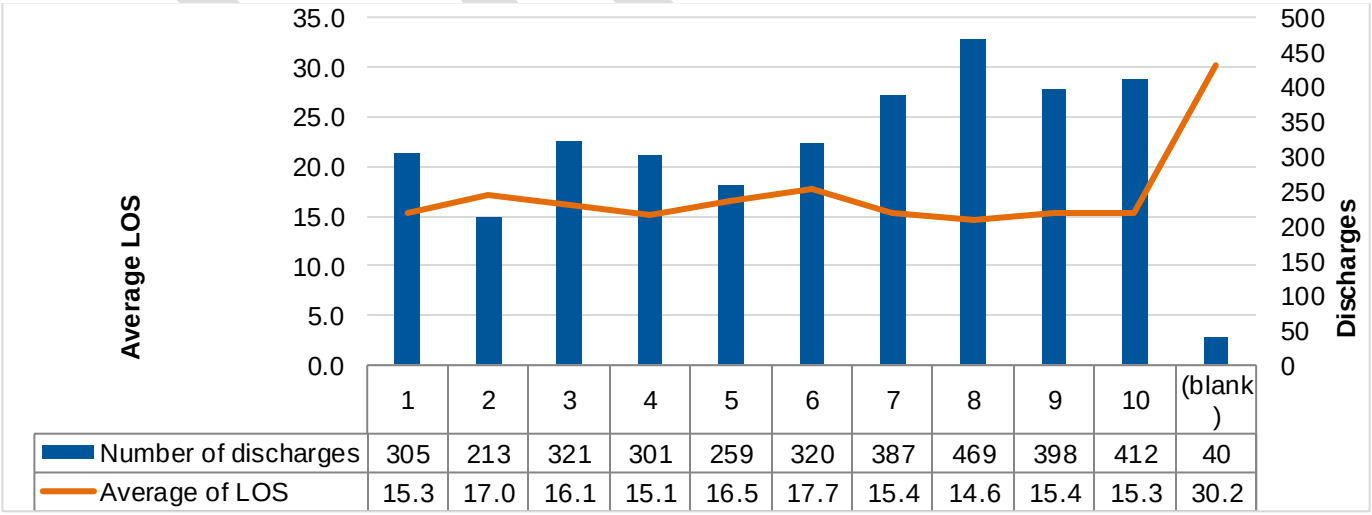
Average LOS and Number of discharges by Age Group



	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109
Number of Discharges	7	20	39	74	175	380	886	1331	506	7
Average LOS	43.71	10.75	13.64	21.93	22.38	17.06	16.14	15.06	13.59	9.57

- Largest proportion of discharged patients aged 80-89 (38.9%)
- Under 50s make up 4.1%
- Median age of Leicester 33 according to 2021 census
- Average LOS 18.5 days (15.7 for 50+)

Average LOS and Number of Discharges by IMD Decile



	1	2	3	4	5	6	7	8	9	10	(blank)
Number of discharges	305	213	321	301	259	320	387	469	398	412	40
Average of LOS	15.3	17.0	16.1	15.1	16.5	17.7	15.4	14.6	15.4	15.3	30.2

- Highest proportion of discharges came from least deprived areas (8 – 13.7%, 9 – 11.6%, 10 – 12.0% compared to 1 – 8.9%, 2 – 6.2%, 3 – 9.4%)

- Leicester was the 32nd most deprived area of 317 local authority district area based on the Indices of Multiple Deprivation 2019

Grading Criteria for Outcome 1A:

Rating	Score	Description	Evidence examples
Underdeveloped activity	0	No or little activity taking place	Organisations/systems have little or nothing in place to ensure patients with protected characteristics have adequate and appropriate access to the services they require. Feedback from patients is not acted upon. Organisations have not identified barriers facing patients.
Developing activity	1	Minimal / basic activities taking place	Data and evidence to show relevant patients with higher risks due to a protected characteristic or at risk of health inequalities (50% of those using the service) have adequate access to the service. Patients consistently report fair or good (or the equivalent) when asked about accessing services. Demonstration that the organisation has identified barriers to accessing services.
Achieving activity	2	Required level of activity taking place	Data and evidence to show relevant patients with higher risks due to a protected characteristic or at risk of health inequalities (75% of those using the service) have adequate access to the service. Patients consistently report good or very good (or the equivalent) when asked about accessing services. Demonstration that the organisation has identified barriers to accessing services.
Excelling activity	3	Activity exceeds requirements	Data and evidence to show relevant patients with higher risks due to a protected characteristic or at risk of health inequalities (98% of those using the service) have adequate access to the service. Patients consistently report very good or excellent (or the equivalent) when asked about accessing services. Demonstration that the organisation has knowledge of barriers and have changed outcomes for people who experience those barriers in accessing services.

Grading score following engagement with key stakeholders

Grading	Result
0 - Undeveloped	0%
1 - Developing	60%
2 - Achieving	40%
3 – Exceeding	0%

Table 1 – Grading scores as a percentage for Outcome 1A where ***Developing*** *is scored highest.*

Reason for scores

‘Deprived areas very overlooked, lack of deeper knowledge on the overall effects of every day, living within the health care and services at home’.

‘Practical experience has been mixed for people and groups I know or have worked with. I think a lot of needs are now being met, but things haven't always been good over recent years.’

‘As data and evidence has shown those who are with higher risks are protected and have adequate access.’

‘Got quite a lot of evidence that verifies’

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Improvement actions suggested were:

1. To be able to really listen to the people's voice, many doctors and nurses have difficulties in communication (Language barriers) so can be very hard to understand at all, and our services is run by outsourcing which is having a huge knock-on effect to the actual NHS, it's the system that don't work.
2. Better communication, better planning and better support during discharge.
3. I suspect this will vary across LLR and can be a postcode Lottery - could the data be broken down into district areas or similar?
4. Understanding the barriers such as language barriers, patients with learning difficulties.

Outcome 1b: Individual patients (service user's) health needs are met

LLR

Data and evidence show that those with higher risk due to protected characteristics or at risk of inequalities have had adequate access, patients report to receiving good level of care and health needs were met. Accessibility to intermediate care is an equal rights service which hasn't demonstrated any form discrimination for those patients with protected characteristics. The service is provided as and when required.

The below data demonstrates that the patients are receiving good level of care, where a clear communication and planning is in place as well as sufficient plans in place once patients are discharged. This clearly demonstrated patients' health needs are met during the stay and post discharge.

Further work is underway to enable us to gather more comprehensive and diverse feedback to ensure any gaps are captured and resolutions are embedded as preventative measures, to eliminate risks or inequalities to those from protected characteristics.

- Whilst in hospital 65% of patients felt they were given support to maintain a good level of independence.
- Feedback suggests 66% patients say they were involved in decisions made about next steps in their care and support
- After leaving hospital 62% felt they were given information about how they would be supported once at home
- 48% say their family/friends were given sufficient information about support and next steps

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- For LLR data suggests that the average LOS of stay is lower for those from minority ethnic backgrounds, and this would suggest a personalised care approach is sufficient and effectively embedded to ensure health needs are appropriately met for service users from protected characteristics and minority groups.
- Enabling service users from minority ethnic groups return home more quickly after a hospital stay with an appropriate after care plan in place for individuals to remain independent in their homes with over **65%** of service users reported that they were provided with information and good communication to develop their personalised care plan in preparation for discharge.

UHL

- UHL data suggests that the average LOS of stay is higher for those from minority ethnic backgrounds. Patients identifying as 'White' have an average LOS of 15.31 days compared to 20.01 days for all other backgrounds.
- Similarly, there are contrasts in average LOS dependant of religion, patients identifying as 'Christian' have an average LOS of 14.87 days, those identifying as 'Muslim' 19.62 days, those identifying as 'Hindu' 17.32 days, those identifying as 'Sikh' 18.24 days and those identifying as 'non-theistic' 16.13 days.
- Overall, males (16.6) had a higher length of stay than females (14.8) (using data sets above 100 discharges per month).
- Longest average LOS age groups were 40-49 (21.93) and 50-59 (22.38), which then steadily drops off for each following group.
- Married (15.50), widowed (14.51) and divorced (14.01) patients had a lower average LOS than single (17.89) patients.
- No recognisable pattern in average LOS regarding to IMD decile, with those on the scale at 1 and 10 having the same LOS (15.3).
- Overall average LOS for all patients on Pathway 1c was 15.87.

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Grading criteria for outcome 1B:

Rating	Score	Description	Evidence examples
Underdeveloped activity	0	No or little activity taking place	Patients with higher risks due to a protected characteristic receive little or no support to self-manage care needs. The organisations do little or no engagement surrounding services.
Developing activity	1	Minimal/ basic activities taking place	Patients at higher risk due to a protected characteristic needs are met in a way that works for them. The organisations often consult with patients and the public to commission, de-commission and cease services provided.
Achieving activity	2	Required level of activity taking place	Patients at higher risk due to a protected characteristic needs are met in a way that works for them. The organisations often consult with patients with higher risks due to a protected characteristic to commission, designed, increase, decrease, de-commission and cease services provided. The organisations signpost to VSCE organisations and social prescribing. Personalised care is embedded into the care delivered for those with higher risks due to a protected characteristic by the organisations.
Excelling activity	3	Activity exceeds requirements	Patients at higher risk due to a protected characteristic and other groups at risk of health inequalities needs are met in a way that works for them. The organisations fully engage with patients, community groups, and the public, to commission, designed, increase, decrease, decommission and cease services provided. The organisations work in partnership with VCSE organisations to support community groups identified as seldom heard. The organisations use social prescribing, where relevant. Personalised care is embedded into the care delivered for those with higher risks due to a protected characteristic by the organisations. The organisations work with, and influence partners, to improve outcomes for people with a protected characteristic and other groups at risk of health inequalities, across the system or where services connect.

Grading score following engagement with key stakeholders

Grading	Result
0 - Undeveloped	0%
1 - Developing	80%
2 - Achieving	20%
3 – Exceeding	0%

Table 2 - *Grading scores as a percentage for Outcome 1B where **Developing** is scored highest.*

Reason for Scores

‘62 percent - patients FELT they were given the information, however nothing impacted on going forward.’

‘Had bad experiences and I am elderly’

‘The data suggests some areas for improvement’

‘From the data it shows that patients’ needs are being met, there is clear communication on next steps, what support is available etc.’

Improvement actions suggested were:

1. Seems lacking knowledge for aftercare that is put into practice, the actual level of care is not to the standards it should be or was used to. Patients feel let down, ignored and just another number for data rather than being treated like a human being.
2. Family members really need any key information on what has been supported and next steps. Again, is there any additional data breakdown, as some of the could be down to follow up care, any access barriers etc?

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3. Patients of ethnic groups to have tailored support, they may not always understand what is being told due to language barriers, not understanding medical terminology, giving them more support where required.

Outcome 1c: When patients (service users) use the service, they are free from harm

LLR

Data and evidence shows that those with higher risk due to protected characteristics or at risk of inequalities have had adequate access, patients report to receiving good level of care and health needs were met and are free form harm Accessibility to intermediate care is an equal rights service which hasn't demonstrated any form discrimination for those patients from protected characteristics, service is provided as and when required, the below principles and standard operating procedures enables service users are free from harm.

LLR Intermediate care leadership have developed various principles to ensure service users are free from harm:

- Work and deliver intermediate care in a collaborative way that optimises independence and wellbeing
- Adaptation of a person-centred approach, taking into consideration cultural differences, disabilities and personal preferences. Adhering appropriately to LLR equality, equity and diversity policies and developing processes to eliminate risks or discrimination.
- Explication engagement across all stages of assessment and delivery, ensuring good communication, and elimination of any barriers between intermediate care practitioners and service users and their families and carers
- Ensuring that the person using intermediate care, their family and carers know who to speak to if they have any questions or concerns about the service, and how to contact them.
- Risk assessments are conducted at each welcome visit, all staff complete health and safety training and provide risk assessments to all carers for each activity.
- Home Care Assessment & Reablement Team HART provides the service user with a welcome pack and a service user guide. A satisfaction form is inserted with pre-paid envelope. Service user guide

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provides information regarding the complaint's procedure and the contact details of the registered manager.

- HART conduct a Q & A with service user towards the end of our service.

To eliminate language, speech, cultural barriers intermediate care offer's service users' various methods and approaches to enable them to sufficiently make decisions about their care and support and be confident, independent and comfortable with the information provided, whilst in hospital or during the after-care planning. Information is offered range of accessible formats, for example:

- Verbally
- In written format (in plain English)
- In other accessible formats, such as Braille or Easy Read, larger fonts
- Translation into other languages
- Interpretation in appropriate languages.

UHL

UHL has several policies in place to protect patients from harm regarding protected characteristics, safeguarding and patient safety:

- Mental Capacity Act training and procedures
- Trust wide EDI strategy
- Patient Safety Incident Response Framework strategy
- Disability policy
- Safeguarding strategy
- Deprivation of Liberty safety standards
- Discharge and transfer of care policy.
- Altered behavior policy.
- Nutrition and hydration policy
- Consent to examination or treatment policy.
- Dentition of patients under the Mental Health Act policy
- End of Life care children and adults
- Ligature risk reduction policy.
- Learning Disabilities and Autism UHL Emergency Department Guideline
- Medication errors policy
- Missing patients' policy
- Rapid flow /outlier's policies

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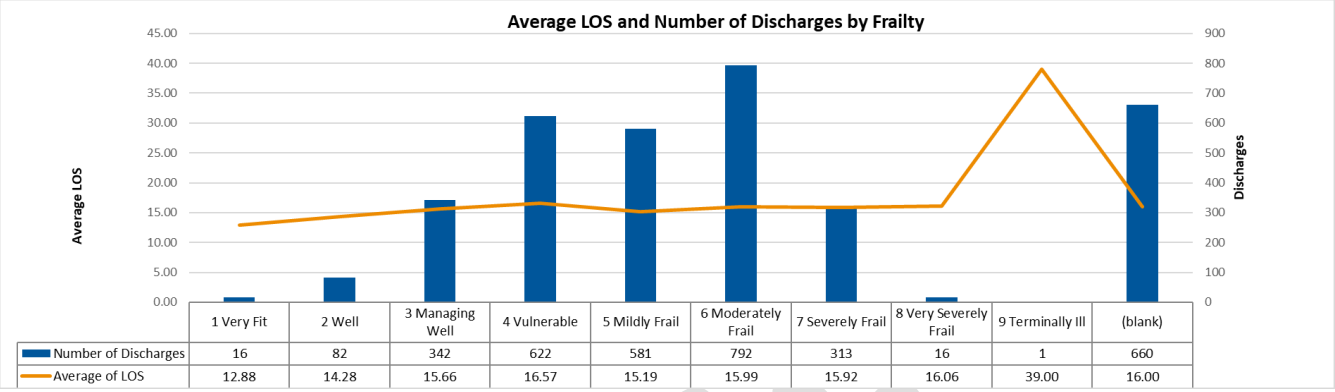
- Restrictive interventions policy



	1 Very Fit	2 Well	3 Managing Well	4 Vulnerable	5 Mildly Frail	6 Moderately Frail	7 Severely Frail	8 Very Severely Frail	9 Terminally Ill	(blank)
Number of Discharges	16	82	342	622	581	792	313	16	1	660
Average of LOS	12.88	14.28	15.66	16.57	15.19	15.99	15.92	16.06	39.00	16.00

- Little significant impact on average LOS due to Frailty score suggests those requiring higher levels of care to ensure patient safety are receiving it.
- Frailty scores used were recorded at the start of the patients' stay.
- Scores are typically given to patients above the age of 65.

UHL also refers to inclusivity as one of the 4 Core Values of the Trust. To achieve this UHL strives to:

- Create a safe space for people of all communities
- Tackle health inequalities through the Health Equality Partnership
- Run workshops for staff around Cultural Safety led by Director of Health Equality and Inclusion (EDI)
- Highlight individual patient experiences around EDI through internal forums
- Find new ways of working to be inclusive including a translated video service in partnership with the local Health Innovation Network
- Use data from patient experience surveys to lead improvement programmes
- Work closely with community leaders and partner organisations to understand the local picture and take action.

Draft

Grading criteria for outcome 1C:

Rating	Score	Description	Evidence examples
Underdeveloped activity	0	No or little activity taking place	The organisation may or may not have mandated/ basic procedures/initiatives in place to ensure safety in services. Staff and patients are not supported when reporting incidents and near misses. The organisation holds a blame culture towards mistakes, incidents and near misses.
Developing activity	1	Minimal / basic activities taking place	The organisation has mandated/ basic procedures/initiatives in place to ensure safety in services. The organisation has procedures/initiatives in place to enhance safety in services for patients in protected characteristic groups.
Achieving activity	2	Required level of activity taking place	The organisation has procedures/initiatives in place to enhance safety in services for patients in all protected characteristic groups where there is known H&S risks. Staff and patients feel confident, and are supported to, report incidents and near misses. The organisation encourages an improvement culture giving consideration to equality and health inequality themes in safety incidents and near misses.
Excelling activity	3	Activity exceeds requirements	The organisation has procedures/initiatives in place to enhance safety in services for all patients in protected characteristic groups where there is known H&S risks. Staff and patients are supported and encouraged to report incidents and near misses. The organisation encourages and promotes an improvement culture actively including equality and health inequality themes in safety incidents and near misses. The organisations work with system and community partners to improve safety outcomes for people, using existing data and driven by service need/risk.

Grading	Result
0 - Undeveloped	0%
1 - Developing	20%
2 - Achieving	**80%**
3 – Exceeding	0%

Table 3 - Grading scores as a percentage for Outcome 1C where Achieving is scored highest.

Reason for Scores

'Mainly the elderly have concerns when using the service but also show high levels of assistance needed for them in hospital that can cause harm to others.'

'Room for improvement to access needs - once access is received service and support is great.'

'Evidence suggests this is being achieved, but I would like to see more evidence.'

'There are robust strategies and policies in place to keep patients safe from harm. Staff understand patients' backgrounds whether cultural or not and they are protected.'

Improvement actions suggested were:

1. Wards for the elderly, separate and bring back morals, high standards and have people paid in the job because they care, not just because it pays the bills.
2. Long waits to access care, ambulance wait times are terrible, hard to make contact with services.
3. I would ask whether family members and carers are there to support more frail or vulnerable users when being questioned? Is there any further information on additional support needs people have?

Outcome 1D Patients (service users) report positive experiences of the service

The 'Voice of the Person Activity' was carried out in July 2023 and involved a series of telephone and some face-to-face interviews conducted by practitioners in Leicester City and Leicestershire. With the target audience being individuals who had recently been through the Discharge process interviews were conducted either with (themselves or family members/carers) to enable us to understand their experiences.

Following provides an overview and both positive and negative experiences received by patients and service users.

- Further Voice of the Person activity is underway and findings to be published June 2025, this shall then provide us with further insight on individuals experiences during their discharge process to enable us to sufficiently eliminate any gaps, risks or operational issue that patients may have experienced.

Draft

- Its fundamental for us to get honest and transparent views on the service you or your family member may have experienced during your/their discharge experience from hospital to your/their home. This can be including the aftercare once you are in your home.
- Any suggestions and thought on future improvements are also very welcomed either utilising the chat box or feedback forms which have been provided to you and can be access via this link: https://forms.office.com/e/bD4hMcG2yt

The staff were amazing they looked after me so well and were always coming over to talk to me which was nice.
Leicester City Resident, Discharged onto Pathway 1

Care was very professional from the doctor and nurses; they organised scans and Xray and always kept me informed about each step.
Leicestershire Resident, Discharged onto Pathway 1

- Whilst in hospital **65%** of patients felt they were given support to maintain a good level of independence.
- Once patients were discharged **48%** felt the support, they received helped them to recover, regain their independence, and enabled them to return to normal daily living prior to hospital stay.
- **44%** of patients say once their hospital treatment had finished, they were discharged as quickly as they wanted to be.
- Feedback suggests **66%** patients say they were involved in decisions made about next steps in their care and support
- After leaving hospital **62%** felt they were given information about how they would be supported once at home
- **48%** say their family/friends were given sufficient information about support and next steps
- Feedback suggests **31%** of carers were provided with sufficient information how they would be supported after hospital discharge

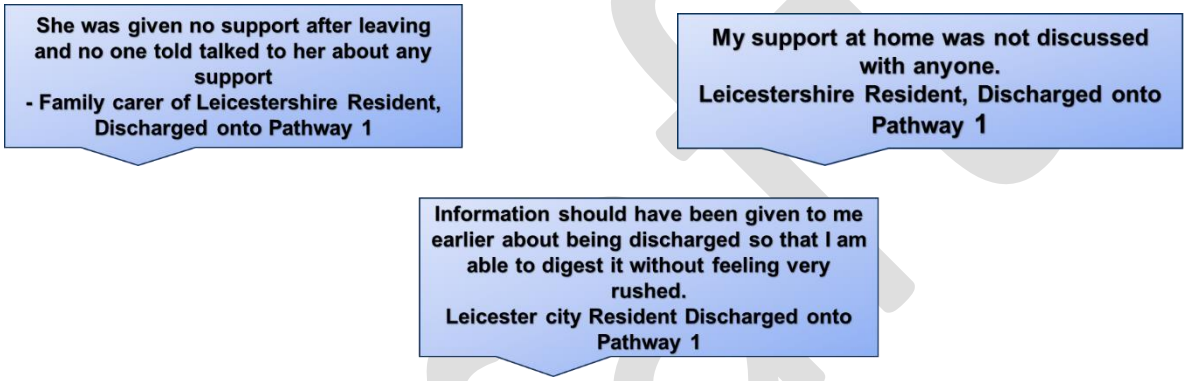
UHL

Discharge Satisfaction Question	Trust	CHUGGS	EM	ITAPS	MSS	RRCV	SM	W&C
Did you feel you were involved in decisions about your discharge from hospital?	81.7	81.6	71.6	98.7	86.0	80.7	76.5	86.4
Was your discharge delayed for any reason?	72.5	72.0	70.4	-	78.4	68.0	68.4	75.0
Were you given any written or printed information about what you should or should not do after leaving hospital?	74.8	78.1	60.1	-	90.9	83.0	61.8	88.9

Draft

- Patients' average satisfaction score regarding to being involved in decisions for their own care at **81.7**
- Patients' average satisfaction score regarding experiencing discharge delays at **72.5**
- Patients' average satisfaction score regarding being provided the correct information following discharge at **74.8**

Negative experiences LLR



- Whilst in hospital **28%** of patients felt they were **Not** given enough support to maintain a good level of independence.
- Once patients were discharged **38%** felt the support, they received **Did Not Help** them to recover, regain their independence, **nor** enabled them to return to normal daily living prior to hospital stay.
- **48%** of patients say once their hospital treatment had finished, they were **Not** discharged as quickly as they wanted to be.
- Feedback suggests **38%** patients say they were **Not** involved in **Any** decisions made about next steps in their care and support.
- After leaving hospital **48%** felt they were **Not** given information about how they would be supported once at home.
- **17%** say their family/friends were **Not** given sufficient information about support and next steps.
- Feedback suggests **27%** of carers were **Not** provided with sufficient information how they would support after hospital discharge

Draft

UHL

Discharge Satisfaction Question	Trust	CHUGGS	EM	ITAPS	MSS	RRCV	SM	W&C
Was your discharge delayed for any reason?	72.5	72.0	70.4	-	78.4	68.0	68.4	75.0
How long was the delay?	21.5	19.9	27.1	-	26.6	23.9	18.8	24.8

- For those patients that did experience a delay in discharge, satisfaction scores around the length of the delay were very low.
- Certain Clinical Medical Groups scored low on all questions – improvement projects ongoing to rectify this.

Key:

- CHUGGS – Cancer, Haematology, Urology, Gastroenterology and Gastro-Intestinal Surgery
- EM – Emergency Medicine
- ITAPS – Intensive Care, Theatres, Theatre Arrivals, Pain and Sleep
- MSS – Musculoskeletal and Specialist Surgery
- RRCV – Renal, Respiratory and Cardiovascular
- SM – Specialist Medicine
- W&C – Women's and Children's

Draft

Grading criteria for Outcome 1D:

Rating	Score	Description	Evidence examples
Underdeveloped activity	0	No or little activity taking place	The organisations do not engage with patients about their experience of the service. The organisations do not recognise the link between staff and patient treatment. The organisations do not act upon data or monitor progress.
Developing activity	1	Minimal / basic activities taking place	The organisations collate data from patients with protected characteristics about their experience of the service. The organisation creates action plans, and monitors progress.
Achieving activity	2	Required level of activity taking place	The organisations collate data from patients with protected characteristics about their experience of the service. The organisations create evidence-based action plans in collaboration with patients and relevant stakeholders, and monitors progress. The organisation shows understanding of the link between staff and patient treatment and demonstrate improvement in patient experiences.
Excelling activity	3	Activity exceeds requirements	The organisation actively engages with patients with protected characteristics and other groups at risk of health inequalities about their experience of the service. The organisation actively works with the VCSE to ensure all patient voices are heard. The organisations create data driven/evidence-based action plans, and monitors progress. The organisation shows understanding of the link between staff and patient treatment. The organisations use patient experience data to influence the wider system and build interventions in an innovative way.

Grading score following engagement with key stakeholders

Grading	Result
0 - Undeveloped	0%
1 - Developing	80%
2 - Achieving	20%
3 – Exceeding	0%

*Table 4 - Grading scores as a percentage for Outcome 1D where **Developing** is scored highest.*

Reasons for Scores

‘Most areas were happy somewhat when receiving hospital treatment, aftercare and lack of practice and knowledge needs improvement.’

‘Some part of service is very positive others are not’.

‘The evidence suggests key areas for improvement.’

‘Most patients have said they feel well supported, they are able to be included in making decisions in their care plan, family feel well informed.’

‘My experience was not very good.’

Improvement actions suggested were:

1. Shocked at this data. We should have the most amazing health care in the world. I personally would like to see ALL these numbers at least 80-90 percent satisfaction overall these areas should be hitting good feedback and responses, we are failing at healthcare full stop. Action needs taking before the demise of our structure as a whole.

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2. My care was good in hospital and staff were great but once I was discharged I had very little support.
3. Particularly concerned about the response from carers - they really need support in their carer roles.
4. The patients who have not felt the same regarding getting that same level of care. How to make that experience better.

Additional Feedback received.

Key findings LLR

- 15% of LLR service users were re-admitted during the diagnostic period.
- Data and evidence show that those with higher risk due to protected characteristics or at risk of inequalities have adequate access, patients report to receiving good level of care and accessibility to the service.
- Majority of the service users during the diagnostic period were between 65-103 years of age (88%), this is very much aligned with frailty and the growing aging population.
- 12% of the service users were under 64 (18-64 years of age)
- Both the male and female population split from non- minority ethnic groups had an average of 3 days of length of stay.
- Those from a minority ethnic groups average length of stay of 2 days both for Male and Female.
- Sufficient risks assessments are in place to ensure service users are free from harm.
- Patients report positive engagement
- Further evaluation will take place from this engagement event to ensure we are developing and aligning next steps in terms of feedback and grading provided from these two engagement events.

Key Findings UHL

- Protected characteristics suggest a significant impact on LOS – those from ethnic or religious minority backgrounds face a longer average stay
- Number of discharges for some characteristics unlike what was expected in relation to area population data
- Higher number of instances coming from the least deprived areas
- Policies are in place to protect patients from harm
- Patients report mostly positive experiences, negative experiences around delays to be looked at
- Overall average LOS 15.87 days

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Next Steps LLR

Key Improvements priorities:

- Further work is underway to enable us to gather more comprehensive and diverse feedback to ensure any gaps are captured and resolutions are embedding as preventative measure, to eliminate risks or inequalities to those from protected characteristics.
- Improve on how data is collated to ensure we are capturing to enable us to eliminate any risks
    - Ethnic groups/Religion/belief
    - Sex,
    - Disability,
    - Marital status
    - Age
    - Specific discharge speciality
    - Sexual orientation
- Develop a Standard Operating Procedure SOP/ Framework to provide explicit service overview to enable us to remove any risks or barriers service users may face, this would also support us to sufficiently carry out frequent evaluations and determine any risks/gaps and rectify as soon as possible.

Key Improvements priorities:

- Individuals service user's feedback/ experiences to be collated at either time of stay, time of discharge or thereafter to enable us to regularly review, prevent and eliminate risks or inequalities to those from protected characteristics focusing on the below outcomes alongside any additional feedback whether this be a positive or negative experience.
    a) Patients (service users) have required levels of access to the service
    b) Individual patients (service user's) health needs are met
    c) When patients (service users) use the service, they are free from harm
    d) Patients (service users) report positive experiences of the service
    e) Develop reporting and grading findings from the engagement events with sufficient evidence to senior leadership team and intermediate care board alongside an EDI and improvement plan.

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- Meeting to be arranged with Intermediate Care leads to discuss findings and ways to embed improvements to eliminate any risk or discrimination.
- Further feedback from service users is currently being collated via health watch.

Next Steps UHL

Improvements changes to be embedded:

- Report findings of this study to senior leadership team and work with EDI leads to plan for improvements.
- Investigate the cause of delays for discharge and how we can reduce the number of instances.
- Ensure patients have the correct access to the services they require.
- Certain CMGs (Clinical Management Groups) scored low on all patient experience questions – improvement projects ongoing to rectify this.

Version 1 18/03/25

Draft

Better Care Fund 2025-26 Update Template

1. Guidance

Overview

HWBs will need to submit a narrative plan and a planning template which articulates their goals against the BCF objectives and how they will meet the national conditions in line with the requirements and guidance set out in the table on BCF Planning Requirements (published).

Submissions of plans are due on the 31 March 2025 (noon). Submissions should be made to the national Better Care Fund england.bettercarefundteam@nhs.net and regional Better Care Managers.

This guidance provides a summary of the approach for completing the planning template, further guidance is available on the Better Care Exchange.

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.
Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
Within the BCF submission guidance there will be guidance to support collaborating across HWB on the completion of templates.

Data Sharing Statement

This section outlines important information regarding Data Sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided. Advice on local information governance which may be of interest to ICSs can be seen at https://data.england.nhs.uk/sudgt/ - Please provide your submission using the relevant platform as advised in submission and supporting technical guidance.

2. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off
National condition one outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. This accountability must not be delegated.

Data completeness and data quality:
- Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
- The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission.

3. Summary

The summary sheet brings together the income and expenditure information, pulling through data from the Income and Expenditure tabs and also the headline metrics into a summary sheet. This sheet is automated and does not require any inputting of data.

4. Income

This sheet should be used to specify all funding contributions to the Health and Wellbeing Boards (HWB) Better Care Fund (BCF) plan and pooled budget for 2025-26. The final planning template will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant and Local Authority Better Care Grant. Please note the Local Authority Better Care Grant was previously referred to as the iBCF. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

Additional Contributions
This sheet also allows local areas to add in additional contributions from both the NHS and LA. You will be able to update the value of any Additional Contributions (LA and NHS) income types locally. If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

Unallocated funds
Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

5. Expenditure

For more information please see tab 5a Expenditure guidance.

6. Metrics

Some changes have been made to the BCF metrics for 2025-26; further detail about this is available in the Metrics Handbook on the Better Care Exchange. The avoidable admissions, discharge to usual place of residence and falls metrics/indicators remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics/indicators.

For 2025-26 the planning requirements will consist of 3 headline metrics and for the planning template only the 3 headline metrics will be required to have plans entered. HWB areas may wish to also draw on supplementary indicators and there is scope to identify whether HWB areas are using these indiciators in the Metrics tab. The narrative should elaborate on these headline metrics [and may] also take note of the supplementary indicators. The data for headline metrics will be published on a DHSC hosted metrics dashboard but the sources for each are also listed below:

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions as well as the projection 65+ population figure on monthly basis
- This will then auto populate the rate per 100,000 population for each month
https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65
Supplementary indicators:
Unplanned hospital admissions for chronic ambulatory care sensitive conditions.
Emergency hospital admissions due to falls in people aged 65+.

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
- This requires inputting the % of total spells where the discharge was on the discharge ready date and also the average length of delay in days for spells where there was a delay.
- A composite measure will then auto calculate for each month described as 'Average length of discharge delay for all acute adult patients'
- This is a new SUS-based measure where data for this only started being published at an LA level since September hence the large number of missing months but early thinking about this metric is encouraged despite the lack of available data.
https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/
Supplementary indicators:
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.
Local data on average length of delay by discharge pathway.

3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
- This section requires inputting the expected numerator (admissions) of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2024-25. Data for this metric is not yet published, but local authorities will collect and submit this data as part of their SALT returns. You should use this data to populate the estimated data in column H.
- The pre-populated cells use the 23-24 SALT data, but you have an option of using this or local data to use as reference to set your goals.
- The pre-populated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) mid-year population estimates. This is changed from last year to standardize the population figure used.
- The annual rate is then calculated and populated based on the entered information.
https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2023-24
Supplementary indicators:
Hospital discharges to usual place of residence.
Proportion of people receiving short-term reablement following hospital discharge and outcomes following short term reablement.

7. National conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund Policy Framework for 2025-26 (link below) will be met through the delivery of your plan. (Post testing phase: add in link of Policy Framework and Planning requirements)

This sheet sets out the four conditions, where they should be completed and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that the HWB meets expectation. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.
In summary, the four National conditions are as below:

- National condition 1: Plans to be jointly agreed
- National condition 2: Implementing the objectives of the BCF
- National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)
- National condition 4: Complying with oversight and support processes
- How HWB areas should demonstrate this are set out in Planning Requirements

Better Care Fund 2025-26 Planning Template

2. Cover

Version 1.5

Please Note:
- The BCF planning template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners (MHCLG, DHSC, NHS England) to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Governance and Sign off

Health and Wellbeing Board:	Leicestershire
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	Yes
If no indicate the reasons for the delay.	
If no please indicate when the HWB is expected to sign off the plan:	

Submitted by:	Lisa Carter
Role and organisation:	Integration Service Manager (BCF Lead)
E-mail:	Lisa.Carter@leics.gov.uk
Contact number:	1163050786
Documents Submitted (please select from drop down) **In addition to this template the HWB are submitting the following:**	Narrative
	C&D National Template

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Cllr	Louise	Richardson	Louise.richardson@leics.gov.uk	Local Authority
	Health and Wellbeing Board Chair					
Named Accountable person	Local Authority Chief Executive	Mr	John	Sinnott	John.Sinnott@leics.gov.uk	Local Authority
	ICB Chief Executive 1	Mrs	Caroline	Trevithick	c.trevithick@nhs.net	ICB
	ICB Chief Executive 2 (where required)	Mrs	Rachna	Vyas	rachna.vyas@nhs.net	ICB
	ICB Chief Executive 3 (where required)					
	LA Section 151 Officer	Mr	Declan	Keegan	Declan.Keegan@leics.gov.uk	Local Authority

Finance sign off	ICB Finance Director 1	Mr	Robert	Toole	robert.toole@nhs.net	ICB
	ICB Finance Director 2 (where required)	Ms	Kitty	Tsui		
	ICB Finance Director 3 (where required)					

Area assurance contacts	Local Authority Director of Adult Social Services	Mr	Jon	Wilson	Jon.Wilson@leics.gov.uk	Local Authority
	DFG Lead	Ms	Julia	Smith	julia.smith@blaby.gov.uk	Local Authority
	ICB Place Director 1	Ms	Rachel	Dewar	rachel.dewar@nhs.net	ICB
Please add any additional key contacts who have been responsible for completing the plan	ICB Place Director 2 (where required)	Ms	Kerryjit	Kaur	kerryjit.kaur2@nhs.net	ICB
	ICB Place Director 3 (where required)					

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	Yes	
National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	Yes	
National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	Yes	

	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	Yes	
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	Yes	

Data Quality Issues - Please outline any data quality issues that have impacted on planning and on the completion of the plan
For discharge ready dates metrics there is a lack of historical data with which to accuratley determine targets. This has also made it difficult to predict and changes in data due to seasonality. A lag in population statistics makes it difficult to determine performance against ASC metrics, however data from previous years' has been taken into consideration in determining targets. Population data also impacts on quality of targets for admissions to long-term care homes data. Using actuals as opposed to rates have been initially calculated to form activity data.

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5. Expenditure	Yes
6. Metrics	Yes
7. National Conditions	Yes

<< Link to the Guidance sheet

^^ Link back to top

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Better Care Fund 2025-26 Planning Template

3. Summary

Selected Health and Wellbeing Board: Leicestershire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£5,518,288	£5,518,288	£0
NHS Minimum Contribution	£57,070,979	£57,070,979	£0
Local Authority Better Care Grant	£21,824,275	£21,824,275	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£84,413,542**	**£84,413,542**	**£0**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26
Minimum required spend	£31,982,219
Planned spend	£32,579,512

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	1,516	1,611	1,669	1,685	1,714

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan
Average length of discharge delay for all acute adult patients	0.45	0.44	0.43	0.42	0.41

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	587.1	140.9	140.9	140.9	140.3

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: Leicestershire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leicestershire	£5,518,288
DFG breakdown for two-tier areas only (where applicable)	
Blaby	£823,673
Charnwood	£1,397,936
Harborough	£635,762
Hinckley and Bosworth	£718,365
Melton	£427,729
North West Leicestershire	£943,749
Oadby and Wigston	£571,074
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£5,518,288**

Local Authority Better Care Grant	Contribution
Leicestershire	£21,824,275
Total Local Authority Better Care Grant	**£21,824,275**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

NHS Minimum Contribution	Contribution
NHS Leicester, Leicestershire and Rutland ICB	£57,070,979
Total NHS Minimum Contribution	**£57,070,979**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	No

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£57,070,979**	

	2025-26
Total BCF Pooled Budget	**£84,413,542**

Funding Contributions Comments
Optional for any useful detail
No additional contributions

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Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Leicestershire

<< Link to summary sheet

	2025-26		
Running Balances	Income	Expenditure	Balance
DFG	£5,518,288	£5,518,288	£0
NHS Minimum Contribution	£57,070,979	£57,070,979	£0
Local Authority Better Care Grant	£21,824,275	£21,824,275	£0
Additional LA contribution	£0	£0	£0
Additional NHS contribution	£0	£0	£0
Total	**£84,413,542**	**£84,413,542**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26		
	Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£31,982,219	£32,579,512	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Disabled Facilities Grant related schemes	Blaby District Council	2. Home adaptations and tech	Other	Local Authority	DFG	£ 681,800	
2	Disabled Facilities Grant related schemes	Charnwood Bororugh Council	2. Home adaptations and tech	Other	Local Authority	DFG	£ 1,256,063	
3	Disabled Facilities Grant related schemes	Harborough Borough Council	2. Home adaptations and tech	Other	Local Authority	DFG	£ 493,889	
4	Disabled Facilities Grant related schemes	Hinckley and Bosworth Borough Council	2. Home adaptations and tech	Other	Local Authority	DFG	£ 576,492	
5	Disabled Facilities Grant related schemes	Melton Borough Council	2. Home adaptations and tech	Other	Local Authority	DFG	£ 285,856	
6	Disabled Facilities Grant related schemes	North West Leicestershire District Council	2. Home adaptations and tech	Other	Local Authority	DFG	£ 801,876	
7	Disabled Facilities Grant related schemes	Oadby and Wigston Borough Council	2. Home adaptations and tech	Other	Local Authority	DFG	£ 429,201	
8	Disabled Facilities Grant related schemes	Integrated Hoarding Planning	2. Home adaptations and tech	Other	Local Authority	DFG	£ 315,000	
9	Disabled Facilities Grant related schemes	Integrated Respiratory Illness	2. Home adaptations and tech	Other	Local Authority	DFG	£ 147,000	
10	Disabled Facilities Grant related schemes	Assistive Technologies and Dementia PILOT	2. Home adaptations and tech	Other	Local Authority	DFG	£ 262,003	
11	Disabled Facilities Grant related schemes	Case worker Pilot	4. Preventing unnecessary hospital admissions	Other	Local Authority	DFG	£ 200,753	
12	Disabled Facilities Grant related schemes	DFG Delivery Project lead	4. Preventing unnecessary hospital admissions	Other	Local Authority	DFG	£ 68,355	
13	Long-term home-based community health services	Community Nursing	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 7,152,110	
14	Long-term home-based community health services	Home First, Nursing & Therapies	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 5,902,964	
15	Discharge support and infrastructure	Discharge Hub	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 252,877	
16	Support to carers, including unpaid carers	LD Short Breaks	3. Supporting unpaid carers	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 928,161	
17	Wider local support to promote prevention and independence	Dementia Services	6. Reducing the need for long term residential care	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 58,000	
18	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	LLR Community Integrated Neurology & Stroke Rehabilitation Service (CINSS)	6. Reducing the need for long term residential care	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 335,271	

19	Urgent community response	Home Visiting Service	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 2,473,560	
20	Urgent community response	Night Nursing Service	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 216,982	
21	Evaluation and enabling integration	Primary Care Coordinator (Falls & Pro-Active Care Coordinator)	4. Preventing unnecessary hospital admissions	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 256,000	
22	Urgent community response	Loughborough Urgent Treatment Centre	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 1,418,929	
23	Urgent community response	Urgent Care Centres (ELRCCG)	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 1,271,250	
24	Long-term residential/nursing home care	Discharge Pathway 3 Contract	5. Timely discharge from hospital	Continuing Care	Private Sector	NHS Minimum Contribution	£ 1,556,956	
25	Discharge support and infrastructure	Primary Care Funding to support D2A placements in care homes	5. Timely discharge from hospital	Primary Care	NHS	NHS Minimum Contribution	£ 131,840	
26	Discharge support and infrastructure	Case management of HD cohort & THC via MLCSU	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 140,271	
27	Discharge support and infrastructure	D2A High Dependency (HD) x15 beds, Plus MH clinical oversight	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 579,076	
28	Discharge support and infrastructure	HD 1-1s for blocked booked beds	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 235,894	
29	Discharge support and infrastructure	D2A HD GP funding to support additional interventions	5. Timely discharge from hospital	Primary Care	NHS	NHS Minimum Contribution	£ 44,238	
30	Discharge support and infrastructure	RVS Discharge Support	5. Timely discharge from hospital	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 108,000	
31	Discharge support and infrastructure	Hospital Staff Training on Home First Process	5. Timely discharge from hospital	Acute	Local Authority	NHS Minimum Contribution	£ 5,387	
32	Housing related schemes	Short-term housing placements	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 52,000	
33	Other	Armed Forces	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 20,000	
34	Wider local support to promote prevention and independence	Home Enteral Nutrition Service (HENS)	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 38,906	
35	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	P2 Hospital Discharge	6. Reducing the need for long term residential care	Social Care	Private Sector	NHS Minimum Contribution	£ 1,465,472	
36	Assistive technologies and equipment	Whzan Boxes	1. Proactive care to those with complex needs	Community Health	Private Sector	NHS Minimum Contribution	£ 150,000	
37	Support to carers, including unpaid carers	Provision for enhanced carer support services- Support to carers	3. Supporting unpaid carers	Social Care	Local Authority	Local Authority Better Care Grant	£ 252,000	
38	Discharge support and infrastructure	Care Homes Support / Trusted Assessor- Discharge to Assess	5. Timely discharge from hospital	Other	Private Sector	Local Authority Better Care Grant	£ 184,400	
39	Discharge support and infrastructure	CHC Commissioning Capacity-Discharge to Assess	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 172,000	
40	Wider local support to promote prevention and independence	Case managers for TCP to support inpatient reductions- Transforming Care Programme	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	Local Authority Better Care Grant	£ 140,000	
41	Long-term home-based social care services	Multi-disciplinary review team for top 100 high cost placements (accomm review team)- Integrated Care	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 242,300	
42	Long-term home-based social care services	Stabilising the social care provider market- Care Providers - Market stabilisation	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 14,489,920	
43	Other	Development of External Workforce-Promotion of Care work	6. Reducing the need for long term residential care	Social Care	Local Authority	Local Authority Better Care Grant	£ 241,110	
44	Evaluation and enabling integration	Health and Social Care Integration Programme-Integration Planning	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 284,400	
45	Assistive technologies and equipment	Technology Enabled Care- Technology Services	2. Home adaptations and tech	Social Care	Local Authority	Local Authority Better Care Grant	£ 1,250,000	
46	Other	Community Discharge Equipment for people with LDA	2. Home adaptations and tech	Other	Local Authority	Local Authority Better Care Grant	£ 17,500	

47	Long-term home-based social care services	Single Handed Care Team-Integration Planning	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 365,400	
48	Long-term home-based social care services	Home First Case Management-Home First	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 638,819	
49	Personalised budgeting and commissioning	HC4L Back Office Support-Home First	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 137,564	
50	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	HART Reablement -Home First	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 1,972,054	
51	Wider local support to promote prevention and independence	Care Coordination -Integrated Care Planning	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 845,327	
52	Wider local support to promote prevention and independence	Care Coordination - OT-Integrated Care Planning	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 56,826	
53	Discharge support and infrastructure	Home First Case Management (Hosp Link Workers)-Discharge to Assess	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 470,910	
54	Discharge support and infrastructure	Home First Integrated Reablement-Discharge to Assess	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 568,172	
55	Housing related schemes	Lightbulb - Housing (Discharge) Enablement Team- Discharge to Assess	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 128,000	
56	Wider local support to promote prevention and independence	Positive Behaviour Support Team-Transforming Care Programme	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 117,842	
57	Wider local support to promote prevention and independence	Enhanced TCP Training Wraparound Service Offer-Transforming Care Programme	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 73,324	
58	Wider local support to promote prevention and independence	Transforming Care Programme - Implementing Actions from the TCP Recovery Plan	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 80,376	
59	Discharge support and infrastructure	Improving Mental Health Discharge	5. Timely discharge from hospital	Mental Health	Local Authority	NHS Minimum Contribution	£ 377,353	
60	Personalised budgeting and commissioning	Mental Health LD Lead Commissioning Arrangements	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 180,692	
61	Support to carers, including unpaid carers	Care Act Enablers	6. Reducing the need for long term residential care	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 97,225	
62	Support to carers, including unpaid carers	Care Act Support Pathway	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 605,382	
63	Long-term home-based social care services	Assessment and Review (ASC protected)	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 2,240,385	
64	Long-term home-based social care services	Home Care Service (ASC protected)	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 15,655,351	
65	Long-term residential/nursing home care	Nursing Care Packages (ASC protected)	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	NHS Minimum Contribution	£ 4,917,262	
66	Support to carers, including unpaid carers	Residential Respite Service (ASC protected)	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 1,014,519	
67	Wider local support to promote prevention and independence	First Contact Plus	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 207,718	
68	Long-term home-based social care services	Integrated Personal Care Framework Training	1. Proactive care to those with complex needs	Community Health	Local Authority	NHS Minimum Contribution	£ 81,400	
69	Wider local support to promote prevention and independence	Post Diagnostic Community & In-Reach Service for people affected by Dementia-Mental Health	6. Reducing the need for long term residential care	Mental Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 281,426	
70	Personalised budgeting and commissioning	Improving Quality in Care Homes	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 738,889	
71	Evaluation and enabling integration	Integration Programme Management	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 495,403	
72	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Intake Model	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 1,266,900	
73	Housing related schemes	MH Relationship Enabler Officer	5. Timely discharge from hospital	Mental Health	Local Authority	Local Authority Better Care Grant	£ 45,000	
74	Discharge support and infrastructure	Assertive Inreach Mental Health	5. Timely discharge from hospital	Mental Health	Local Authority	Local Authority Better Care Grant	£ 170,600	

75	Other	Social Workers MH discharge and review team	6. Reducing the need for long term residential care	Social Care	NHS Mental Health Provider	Local Authority Better Care Grant	£ 157,500	
76	Discharge support and infrastructure	CSW In hospital Team	5. Timely discharge from hospital	Mental Health	Local Authority	Local Authority Better Care Grant	£ 89,000	
77	Assistive technologies and equipment	System One Licenses	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 5,000	
78	Personalised budgeting and commissioning	Brokerage Team	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 163,300	
79	Evaluation and enabling integration	Case Managers -Care Assessments	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 439,200	
80	Discharge support and infrastructure	Flow Improvement Team	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 616,500	
81	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	Home first team support workers	6. Reducing the need for long term residential care	Social Care	Local Authority	Local Authority Better Care Grant	£ 76,000	
82	Housing related schemes	Housing Enablement Team Expansion	5. Timely discharge from hospital	Acute	Local Authority	Local Authority Better Care Grant	£ 165,760	
83	Personalised budgeting and commissioning	Lead commissioner post	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 82,000	
84	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Care packages to support HART capacity rejections	5. Timely discharge from hospital	Social Care	Private Sector	Local Authority Better Care Grant	£ 883,000	
85	Discharge support and infrastructure	Hospitals Team	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 25,485	
86	Discharge support and infrastructure	Therapy	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 124,998	
87	Discharge support and infrastructure	LD Discharges	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 17,500	
88	Wider local support to promote prevention and independence	Falls Prevention - Steady Steps	4. Preventing unnecessary hospital admissions	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 152,118	

5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS minimum:

- **Area of spend** selected as 'Social Care' and **Source of funding** selected as 'NHS Minimum Contribution'

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:
1. Scheme ID:
- Please enter an ID to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. Description of Scheme:
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.
4. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
6. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the NHS or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:
Any further information that may help the reader of the plan. You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description
1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	DFG related schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.
4	Wider support to promote prevention and independence	Prevention/early intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes a range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services

6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period.
7	Long-term home-based social care services	Personalised care at home	Long-term schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
10	Long-term residential or nursing home care	Residential placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.
15	Urgent Community Response	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: Leicestershire

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,714	1,689	1,698	1,724	1,753	1,588	1,737	1,620	n/a	n/a	n/a	n/a	The rationale for this target has been agreed across LLR. The target recognises that there has been a year on year increase in admissions since 22-23. The aim is to return to 0.8% better than 23-24 admissions numbers. This is a stretch target as it negates the projected 25-26 increase of 2% (also seen in 24-25) and further reduces this by 0.8% to see a reduction on 23-24 actuals. This is also against the projected POPPI increase in over 65 population of an additional 4%. The narrative shows how it is proposed that individual schemes will impact on the target set. The schemes are targeted at reducing admissions for chronic abulatory conditions which saw an increase of 16% in demand in 24-25 and further support to reduce admissions due to falls.
	Number of Admissions 65+	2640	2,600	2,615	2,655	2,700	2,445	2,675	2,495	n/a	n/a	n/a	n/a	
	Population of 65+*	153,982	153,982	153,982	153,982	153,982	153,982	153,982	153,982	n/a	n/a	n/a	n/a	
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
	Rate	1,516	1,611	1,669	1,685	1,714	1,559	1,627	1,588	1,633	1,617	1,552	1,692	
	Number of Admissions 65+	2335	2480	2570	2595	2640	2400	2505	2445	2515	2490	2390	2605	
	Population of 65+	153,982	153,982	153,982	153,982	153,982	153,982	153,982	153,982	153,982	153,982	153,982	153,982	

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.69	0.66	0.66	n/a	n/a	n/a	n/a	The ambition for these metrics have been set across the LLR system to align with the target set for criteria to reside. This is currently set at 11% of patients in the acute with no criteria to reside. For the DRD metric the target has been set at 89% to correspond with this. This represents an improvement of 4% on the current data. Activity to reach this target is aligned to acute trust plans particularly around reducing P0 delays. Data on the
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	84.6%	85.1%	84.5%	n/a	n/a	n/a	n/a	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	4.5	4.4	4.3	n/a	n/a	n/a	n/a	

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
Average length of discharge delay for all acute adult patients	0.45	0.44	0.43	0.42	0.41	0.40	0.38	0.38	0.36	0.35	0.34	0.33	amount of patients 1 day to over 21 days delayed has been utilised to show how the schemes will impact on this along with data on the LOS past MOFD for pathways 1-3. Schemes and their impact have been listed in the narrative in more detail. The current performance on numbers of days from DRD to discharge is 3.6 for Leics (excluding P0). The aim is to reduce this to 3 days over the course of the year. This can't be reflected in the spreadsheet as it will only accept whole numbers entered at line 39. Improvement to pathways 1-3 discharges will have a small impact on delays overall. Plans are aligned to UHL targets of 66% P0 patients discharged on their DRD.
Proportion of adult patients discharged from acute hospitals on their discharge ready date	85.0%	85.4%	85.7%	86.1%	86.5%	86.8%	87.2%	87.5%	87.9%	88.3%	88.6%	89.0%	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	Yes
Local data on average length of delay by discharge pathway.	Number of days	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	509.8	511.7	587.1	140.9	140.9	140.9	140.3		The current projection for this indicator is that for 24-25 the projected number of admissions is 904. This represents an increase of 5% on the previous years admissions numbers (865). The target for 25-26 is to return to the numbers seen in 23-24 (approx admissions of 216-217 per month. This is a stretch target based on reducing the current data against a projected population increase in over 65's of 4%.
	Number of admissions	785	788	904	217	217	217	216		
	Population of 65+*	153,982	153,982	153,982	153,982	153,982	153,982	153,982		

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	No

HM Government

NHS England

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: Leicestershire

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes			Yes
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	Yes			Yes
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes			Yes
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care					
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes

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BCF Capacity & Demand Template 2025-26

1. Guidance

Overview

This template has been unlocked to allow editing as required. It is optional to submit capacity & demand figures as per this template format and a customised format of this will be accepted.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data can be input into the cell
Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. You should select your HWB from the top of the sheet which will also reveal pre-populated trusts for your area.

2. Once you are satisfied with the information entered the template should be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

3. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

This template follows the same format as last year and so contains all the previously asked for data points including demand (referrals), block and spot capacity, average duration of treatment and time from referral to treat all split by pathway. It is however only required that some form of data points are submitted to show projected demand (disaggregated by step-up and step-down) and capacity for intermediate care and other short term care. The additional data points on average treatment time, time to treat and spot/block capacity split are optional but have remained in case you may find these data points useful.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

List of data points in template:

3.1 C&D Step-down

Estimates of available capacity for each month of the year for each pathway.
Estimated average time between referral and commencement of service.
Expected discharges per pathway for each month, broken down by referral source.
Estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways.

3.2 C&D Step-up

Estimated capacity and demand per month for each service type.
Estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

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Better Care Fund 2025-26 Capacity & Demand Template

2. Cover

Version 1.1

Health and Wellbeing Board:	Leicestershire
Completed by:	Lisa Carter
E-mail:	lisa.carter@leics.gov.uk
Contact number:	1163050786
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes

Once complete please send this template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'C&D - Name HWB' for example 'C&D - County Durham HWB'. Please also copy in your Better Care Manager.

<< Link to the Guidance sheet

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Better Care Fund 2025-26 Capacity & Demand Template

3.1. C&D Step-down

Selected Health and Wellbeing Board: Leicestershire

Step-down

Capacity - Demand (positive is Surplus)	Capacity surplus (not including spot purchasing)												Capacity surplus (including spot puchasing)											
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	-116	-82	-54	-123	-111	-116	-117	-120	-120	-148	-136	-114	-34	12	15	-18	7	-39	7	2	0	-5	-6	-6
Short term domiciliary care (pathway 1)	-64	-84	-68	-81	-77	-56	-73	-53	-26	-80	-44	-64	0	0	0	0	0	-1	0	0	-1	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-63	-65	-67	-65	-68	-69	-80	-70	-55	-90	-77	-70	1	0	0	0	0	0	0	-1	-1	0	0	0
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-12	-26	-13	-10	-10	-13	-16	-10	-8	-4	-11	-12	0	-1	0	0	0	0	-1	0	0	0	0	0

Average LoS/Contact Hours per episode of care

Full Year	Units
13	Contact Hours per package
17	Contact Hours per package
28	Average LoS (days)
31	Average LoS (days)
28	Average LoS (days)

Capacity - Step-down

Service Area	Metric	Refreshed planned capacity (not including spot purchased capacity)												Capacity that you expect to secure through spot purchasing											
		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	517	527	506	531	485	503	516	517	527	506	503	512	82	94	69	105	118	77	124	122	120	143	130	108
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	1	1	1	1	1	1	1	1	1	1	1	1												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	64	84	68	81	77	55	73	53	25	80	44	64
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	1	1	1	1	1	1	1	1	1	1	1												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	191	186	189	202	199	172	190	179	191	207	183	194	64	65	67	65	68	69	80	69	54	90	77	70
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	2	2	2	2												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	3	12	6	9	12	8	8	8	8	8	8	8	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	2	2	2	2												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	12	25	13	10	10	13	15	10	8	4	11	12
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	10	10	10	10	10	10	10	10	10	10	10	10												

Demand - Step-down

Please enter refreshed expected no. of referrals:

Pathway	Trust Referral Source	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Expected Step-down:	Total Step-down	**966**	**982**	**903**	**1021**	**962**	**937**	**1000**	**957**	**935**	**1043**	**962**	**974**
Reablement & Rehabilitation at home (pathway 1)	Total	**633**	**609**	**560**	**654**	**596**	**619**	**633**	**637**	**647**	**654**	**639**	**626**
	LEICESTERSHIRE PARTNERSHIP NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	443	426	392	458	417	433	443	446	453	458	447	438
	OTHER	190	183	168	196	179	186	190	191	194	196	192	188
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Short term domiciliary care (pathway 1)	Total	**64**	**84**	**68**	**81**	**77**	**56**	**73**	**53**	**26**	**80**	**44**	**64**
	LEICESTERSHIRE PARTNERSHIP NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	45	59	48	57	54	39	51	37	18	56	31	45
	OTHER	19	25	20	24	23	17	22	16	8	24	13	19
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Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**254**	**251**	**256**	**267**	**267**	**241**	**270**	**249**	**246**	**297**	**260**	**264**
	LEICESTERSHIRE PARTNERSHIP NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	178	176	179	187	187	169	189	174	172	208	182	185
	OTHER	76	75	77	80	80	72	81	75	74	89	78	79
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Other short term bedded care (pathway 2)	Total	**3**	**12**	**6**	**9**	**12**	**8**	**8**	**8**	**8**	**8**	**8**	**8**
	LEICESTERSHIRE PARTNERSHIP NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	2	8	4	6	8	6	6	6	6	6	6	6
	OTHER	1	4	2	3	4	2	2	2	2	2	2	2
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**12**	**26**	**13**	**10**	**10**	**13**	**16**	**10**	**8**	**4**	**11**	**12**
	LEICESTERSHIRE PARTNERSHIP NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	8	18	9	7	7	9	11	7	6	3	8	8
	OTHER	4	8	4	3	3	4	5	3	2	1	3	4
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Better Care Fund 2025-26 Capacity & Demand Template

3.2. C&D Step-up

Selected Health and Wellbeing Board: Leicestershire

Step-up **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	-55	-69	-50	-105	-55	-41	-45	-36	-41	-69	-43	-55
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	55	69	50	105	55	41	45	36	41	69	43	55

Average LoS/Contact Hours	
Full Year	Units
2	Contact Hours
11	Contact Hours
28	Average LoS
14	Contact Hours

Capacity - Step-up

Please enter refreshed expected capacity:

Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	Monthly capacity. Number of new clients.	263	220	260	221	193	215	218	175	125	186	177	205
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	890	846	811	917	788	784	869	805	781	861	849	837
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	212	148	133	133	124	125	122	111	110	119	168	137
Other short-term social care	Monthly capacity. Number of new clients.	55	69	50	105	55	41	45	36	41	69	43	55

Demand - Step-up

Please enter refreshed expected no. of referrals:

Service Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	263	220	260	221	193	215	218	175	125	186	177	205
Reablement & Rehabilitation at home	945	915	861	1022	843	825	914	841	822	930	892	892
Reablement & Rehabilitation in a bedded setting	212	148	133	133	124	125	122	111	110	119	168	137
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

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Agenda Item 14

HEALTH AND WELLBEING BOARD: 29 MAY 2025

REPORT OF THE INTEGRATION EXECUTIVE

JOINT HEALTH & WELLBEING STRATEGY PROGRESS UPDATE ON LIVING & SUPPORTED WELL AND DYING WELL

Purpose of report

1. The purpose of the report is to provide an update to the Health and Wellbeing Board (HWB) on progress in relation to the Living & Supported Well and Dying Well strategic priorities of the Joint Health and Wellbeing Strategy (JHWS) 2022-32.

Recommendation

2. The Board is requested to:

   a. Note the progress being made in relation to delivering against the Living and Supported Well & Dying Well strategic priorities;
   b. Note the progress being made in relation to delivering against the cross-cutting priorities.

Background

3. One of the statutory requirements of the HWB is to produce and deliver a JHWS. A Joint Strategic Needs assessment (JSNA) was carried out to provide the evidence base to identify the health and wellbeing needs of the local population. The JSNA along with contributions from key partners and stakeholders, helped to inform the JHWS priorities.

4. The ten-year JHWS was approved in February 2022 and aims to improve the health, wellbeing and equity outcomes of Leicestershire. The strategy follows a life course approach:

   a. Best Start for Life;
   b. Staying Healthy, Safe and Well;
   c. Living and Supported Well;
   d. Dying Well.

5. Three HWB subgroups deliver the priorities within each specific life course. A fourth subgroup was established in January 2023 to specifically address the mental health needs across Leicestershire, recognising it cuts across all life courses and requires a greater focus.

6. Reducing health inequalities remains a cross-cutting theme and underpins the work of all four subgroups.

7. The Integration Executive is responsible for overseeing the delivery of the Living and Supported Well and Dying Well strategic priorities of the JHWS and has a role to play in delivery of the cross-cutting priorities. The two priority areas including the sub-priorities are listed below.

   - **Living & Supported Well:**
     a. Upscaling Prevention and Self-Care;
     b. Effective Management of Frailty and Complex Care.

   - **Dying Well:**
     a. Understanding Need;
     b. Effective Transitions;
     c. Normalising End of Life Planning.

8. A report on progress was presented to the Health and Wellbeing Board in May 2024.

9. This report provides an update on progress since the last report, challenges that would benefit from input from the Board, and plans for the next 12 months in continuing to deliver against the Living & Supported Well and Dying Well priorities of the JHWS.

Progress against the Living & Supported Well and Dying Well priorities of the JHWS

10. The table below details the progress being made against each of the priority areas and commitments:

JHSW Priority 1: Upscaling Prevention and Self-Care

Activity	Detail	Beneficiaries	BCF Investment 24-25	Commitments
Care Co-ordination	A Health and Social Care proactive care approach using risk stratification within the community enabling patients to receive the 'right care, at the right time, at the right place'. 19.5 FTE	6486	£724,160	Empower patients to self-manage their long-term condition(s)
Falls – care homes	Reducing the amount of fallers in the care homes with the highest incidences	1381 approx	Core funding	Reducing the number of falls within care homes
Falls – DHU car	Responding to falls in the community to support at home avoiding admission to hospital	1214 referrals	Ageing Well	Reducing admissions due to falls
DFG's	Disabled Facilities Grants help towards the costs of making changes to peoples' home so they can continue to live there.	385	£3,834,762	People living with disability and long-term conditions have access to the right housing, care and support.
Mental Health relationship officer	Supporting people being discharged from Mental Health facilities to remain in the community, prevent readmission and to enable self-care	69	£262,053	Provide joined up services that support people and carers to live independently for as long as possible

LD short breaks	Providing a stay in an appropriate setting away from home for a short time to give a carer a break from caring	133	£985k	Supporting people and carers to live as independently as possible and implementing the LLR Carers strategy
First contact plus	First Contact Plus is an online tool which helps adults in Leicestershire find information about a range of services all in one place.	9989	£199k	Improving access to health and care services
Assistive Technology	Offering a wide range of equipment to maintain independence at home	929	£1 million	Patients self-manage their long-term condition(s) through digital approaches, assistive technology, accessible diagnostics and support
Housing Enablement Team	Integrated housing offer within clinical care settings, focused on delivering health and wellbeing outcomes for patients to maximise opportunities to contribute towards safe and timely discharges from hospitals	2160	£286,760	People living with disability and long-term conditions have access to the right housing, care and support
Urgent Care Centres	Provision of walk-in clinics focused on the delivery of urgent ambulatory care in a dedicated medical facility outside of a traditional emergency department	144,000	£2.65 million	Work to improve access to health and care services including primary care and appropriate funding support

JHWS Priority 2: Effective Management of Frailty & Complex Care

Activity	Detail	Beneficiaries	BCF Investment 24-25	Commitments
System one shared access	Support services to access real time data across the IDT and MH teams to better communicate with each other on the status of patients	125 staff	£15k	Improving access to health and care services
Integrated HART reablement and therapy teams	Reablement in a person's own home to maximise independence and reduce care needs including the integrated locality teams for therapy and HART	4436 HART 19,000 Therapy	£1.7 million HART £5.4 million Therapy	Provide joined up services that support people and carers to live independently for as long as possible aiming for a 2 day start for all requests
Home first teams	Support for those in hospital to return home or to a discharge to assess bed and step-up support for those in the community needing support	6421	£2 million	Delivering an effective health and care integration programme that will deliver the Home First step-up and step-down approach for Leicestershire.
Domiciliary care	Support from independent providers for care packages in the home	4105 people 623,483 hours	£15 million BCF and iBCF contributions	Reducing the number of permanent admissions to residential and nursing homes.
Royal Voluntary Service discharge support	Supports people leaving hospital on pathway 0. Ensuring safe and timely discharge, ongoing support in the community and reducing risk of readmissions	792	£108k	Effective health and care integration programme that will deliver the Home First step up and step-down approach for Leicestershire.

High dependency beds	Commissioned D2A beds for those with high-dependency needs	N/A	£229,630	Reducing the number of permanent admissions to residential and nursing homes.
Nursing care	Supporting people with health and care needs in short and long-term nursing placements	237	£4.8 million	Supporting the creation of an integrated health and social care workforce
Residential respite	Providing a stay in a care home for a short time to give a carer a break from caring	151	£976,170	We will provide joined up services that support people and carers to live independently for as long as possible, including those with dementia
Community response service / HART urgents	Interim support service that provides quick targeted interventions to those in the community that need it to remain at home and avoid admissions	550	£1 million	Offer a two-hour crisis response for people that may otherwise need to attend hospital, reducing admissions and increasing community care capacity

Progress against the Dying Well Priority of the JHWS

11. End of life planning is delivered across Leicester, Leicestershire and Rutland and delivery is supported by a series of workstreams. Deliverables are not only aligned to the JHWS commitments but also to workstreams. These are listed below:

- Workstream 1: Health equity in Palliative and End of Life Care (Y1A1)
- Workstream 2: Data review and standardisation / Shared Care Record
- Workstream 3: Training and workforce development
- Workstream 4: Improving ReSPECT and Advance Care Planning
- Workstream 5: Communication, information & engagement

- Workstream 6: Service provision and care transfer
- Workstream 7: Improving access to Anticipatory Medication in the community

JHWS Priority 1: Understanding Need

JHWS Priority	JHWS Commitment	Key Intervention	Workstream
Understanding the need	We will carry out a Joint Strategic Needs Assessment chapter looking at end of life specifically We will use our better understanding of needs through the EoL JSNA chapter to consider other aspects of end-of-life planning	UndertakAs part of the End of Life LLR strategy led by ICB (final sign off due July 2025) an assessment of local PEoLC needs was undertaken in each of our three upper tier local authorities, to inform the development of this Strategy. These Joint Strategic Needs Assessments (JSNAs) reviewed the population health needs of the people of LLR in relation to end of life care and support. This involved looking at: • the issues that determine the end of life; • the health needs of the population; • the policy and guidance supporting end of life care and support; and • the existing services and the breadth of services that are currently provided. The full JSNAs can be found at: Leicestershire County Council	1
	We will seek to gather views from people to understand what dying well means to them and how this could be achieved	Public engagement began in August 2024. Findings from the engagement were analysed to build into the refresh of the strategy and the draft strategy was updated based on feedback received	5

JHWS Priority 2: Effective Transitions

JHWS Priority	JHWS Commitment	Key Intervention	Workstream
Effective Transitions	We will seek your views on what planning and services for late and end of life should look like and how you should be informed about your choices	A health equity audit to examine how health determinants, access to services, and related outcomes are distributed across the population was developed as part of the JSNA	1
		Gain common understanding of current challenges relating to access of patient information and shared care records between settings / organisations, scoping interventions required from Year 2 onwards.	2
		Review of patient and professional information and engagement (platforms and language) to include family and carer support has begun to feed into the deliverables from the strategy	5
	We will ensure there is a clear transition in care planning from living with long term conditions into the later and end of life	Pilots have taken place within VW's for frailty to include delivery of palliative care needs for this cohort	7
		The mapping of current service provision and identify gaps in service is still being developed and will become part of the Neighbourhood models of care delivery	6
	We will ensure there is appropriate support for carers following the bereavement of a loved one so they can have a supportive transition into the next stage of their lives	Review of patient and professional information and engagement (platforms and language) to include family and carer support.	5
		Pilot a new approach to AM in the community to include delivery to patient's home. Underpinning improvements are required around the authorisations process (underway), education and training (recognising dying / deterioration / symptom management), access to equipment (eg. Syringe drivers), formulary – routes and quantities.	7

JHWS Priority 3: Normalising End of Life Planning

JHWS Priority	JHWS Commitment	Key Intervention	Workstream
Normalising End of Life Planning	We will offer care plans and ReSPECT plans to all vulnerable people with a take up target of 95%	Review of the audit, current uptake and quality took place as part of the initial refresh of the strategy	4
	We will develop a social marketing campaign based on insight to normalise end of life planning	Review of patient and professional information and engagement (platforms and language) to include family and carer support has begun as part of the engagement work on the strategy review	5
	We will educate our workforce so that everyone understands how to support people at end of life	Review of the training matrix, developed in 2022/23, has began to be developed with delivery suring 25-26	3
		Performance framework for the delivery of the strategy has been developed.	3
	We will improve co-ordination of care at end of life, as measured through patient feedback	Public engagement began in August 2024. Findings from the engagement were analysed to build into the refresh of the strategy and the draft strategy was updated based on feedback received	7
		Develop a live service directory.	6

Progress against cross-cutting priorities of the JHWS

JHWS Cross-cutting priorities:

- **Improved mental health**
- **Reducing health inequalities**
- **Covid-19 recovery**

HWBB priority	Activity	Detail	Beneficiaries	BCF Investment 24-25	Commitments
Improved mental health	Transforming Care Programme	A wide range of staffing and support services for those who have learning disabilities detained under the mental health act	N/A	£366,863	Prioritises Mental Health on an equal basis to physical health in plans, investment and focus also considering the links between physical activity and good mental health and how mental health is linked to other conditions.
	Improving mental health discharges	Teams working within mental health care settings enabling people to manage their conditions and maximise independence on discharge	N/A	£341,251	Teams working within mental health care settings enabling people to manage their conditions and maximise independence on discharge
	High dependency support	Providing case management, 1:1 care in a bedded setting for those with high level needs and behaviours (including dementia care)	146	£916k	Supporting key recommendations of the Dementia JSNA Chapter and LLR Dementia Strategy

	MH social workers and advocacy support	Specialist teams to support patients to recover from periods of ill health. Helping them to maximise independence with and Mental Health support	N/A	£198k	Prioritises Mental Health on an equal basis to physical health in plans, investment and focus particularly in supporting MH discharges

HWBB priority	Activity	Detail	Beneficiaries	BCF Investment 23-24	Outcomes
Reducing health inequalities	Shared care records	Shared care records assist staff to make the best decisions by having a more joined-up picture of information. This is important in providing safe, personalised, and connected care to all on an equitable basis	All		Equitable access, excellent experiences and optimal outcomes for all those using health and care services across Leicestershire
	System one unit for Mental Health	Providing a discharge unit for Mental Health settings to enable joined up discharge planning across partners and equitable outcomes across all patient bed bases.	N/A		Equitable access, excellent experiences and optimal outcomes for all those using health and care services across Leicestershire

Reducing health inequalities	Additional housing units	Supporting complex housing discharges and reducing delays by providing short-term accommodations for people who are ready to leave hospital but where home is not yet suitable	N/A	£61k	Varying services in response to differences in need within and between groups of people, that will aim to bring those experiencing poorer outcomes the opportunity to 'level up' to those achieving the best outcomes

12. Across the financial year we have seen improved performance in the following areas:

    - Reduced waits for domiciliary care package pick ups;
    - Increased reablement service capacity by 40%;
    - Discharge Pathway 2 bed usage reduced by 36% over 2 years;
    - 84% on average people have no further need post reablement with 89% people still at home 91 days post receipt of reablement;
    - Size of care packages reduced right-sized to peoples needs;
    - Discharge pathway 1 length of stay post medically optimised for discharge has reduced from 4 days to 2 days, Pathway 2 reduced from 11.5 to 7.5 days and Pathway 3 reduced from 18 days to 17.5 days;
    - Reduction of 7 days length of stay per person utilising the Hight Dependency discharge pathway;
    - Increase in people receiving housing support from the Housing Enablement Team – up more than 35% in 24/25 from 23/24 (1583 in 23-24, 2160 in 24-25);
    - Reduction in the number of people admitted to hospital after a fall from care homes – approx. 50% reduced;
    - Reduction in hip fractures due to a fall – in line with England average;
    - Fully integrated HART reablement and therapy locality teams in the County, resulting in workforce time saved 0.5 days per team per locality helping to increase capacity and reduce waiting times;
    - Better collaboration between partners and services and improved outcomes for service users integrated training sessions across partners;
    - Nationally recognised for work on the High Dependency cohort within intermediate care;

13. Whilst we have made great strides in the areas described above, Leicestershire continues to experience challenges in the following areas:

    - Overall demand on social care services continues;
    - Admissions into hospitals continued to increase in 24-25 as did admissions to care homes
    - Challenges remain around staffing meeting demand for services regardless of whether funding is available to support expansion;
    - Primary care access remains a challenge;

Next Steps

14. Over the next 12 months the focus on improvements to health and social care services in Leicestershire will focus on moving services closer to communities. This will be based on the emerging Neighbourhood models of care which will seek to deliver a wider range of care and support in peoples own homes.

15. Step-up care will be the focus of our Intermediate Care programme of work; building on the successes of the step-down focus for the past two years.

16. Proactive management of demand and a renewed focus on prevention will form part of the strategic approach of all work programmes.

17. Bedded care requirements will be partly met within 25-26 with current plans in place to bridge the gap in discharge to assess bedded requirements.

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Agenda Item 15

HEALTH AND WELLBEING BOARD: 29 MAY 2025

REPORT OF THE STAYING HEALTHY PARTNERSHIP

JOINT HEALTH & WELLBEING STRATEGY PROGRESS UPDATE ON STAYING HEALTHY, SAFE & WELL

Purpose of report

1. The purpose of the report is to provide an update to the Health and Wellbeing Board (HWB) on progress in relation to the Staying Healthy, Safe & Well priority of the Joint Health and Wellbeing Strategy (JHWS) 2022-32.

Recommendation

2. The Board is requested to:

   a. Note the progress being made in relation to delivering against the Staying Healthy, Safe & Well priority.

   b. Note the progress being made in relation to delivering against the cross-cutting priorities.

Background

3. One of the statutory requirements of the HWB is to produce and deliver a JHWS. A Joint Strategic Needs assessment (JSNA) was carried out to provide the evidence base to identify the health and wellbeing needs of the local population. The JSNA along with contributions from key partners and stakeholders, helped to inform the JHWS priorities.

4. The ten-year JHWS was approved in February 2022 and aims to improve the health, wellbeing and equity outcomes of Leicestershire. The strategy follows a life course approach:

   a. Best Start for Life;
   b. Staying Healthy, Safe and Well;
   c. Living and Supported Well;
   d. Dying Well.

5. Three HWB subgroups deliver the priorities within each specific life course. A fourth subgroup was established in January 2023 to specifically address the

mental health needs across Leicestershire, recognising it cuts across all life courses and requires a greater focus.

6. Reducing health inequalities remains a cross-cutting theme and underpins the work of all four subgroups.

7. The Staying Healthy, Safe and Well strategic priority is split into two priority areas. Each priority area includes a set of commitments.

    a. Building Strong Foundations;
    b. Enabling Healthy Choices & Environments.

8. The Staying Healthy Partnership is responsible for overseeing the delivery of the Staying Healthy, Safe and Well strategic priority of the JHWS and has a role to play in delivery of the cross-cutting priorities.

9. A report on progress was presented to HWB in May 2024.

10. This report provides an update on progress since the last report, challenges that would benefit from input from the HWB, and plans for the next 12 months in continuing to deliver against the Staying Healthy, Safe & Well strategic priority of the JHWS.

Progress against the Staying Healthy, Safe & Well strategic priority of the JHWS

11. The table below details the progress being made against each of the priority areas and commitments:

JLHSW Priority 1: Building Strong Foundations

Health in all Policies (HiAP)

- Health in All Policies in the County Council successfully embedded.
    - In excess of 150 have enrolled on the e-learning – this is open to all members of staff and has been completed from staff members from different departments
    - Just over 100 members of LCC staffed trained on the Health in All Our Decisions training. This has been rolled out within Leicestershire – we have prioritised teams and departments to train so far the training has been delivered to Democratic Services, Chief Executives team, Growth team, Environment and Transport management, Policies, and Education.
- Currently the HiAP training is being evaluated and a lesson learnt report is in progress.
- Further improvements in horizon scanning and agreements with Democratic Services, Policies Team and Transformation Team have been made.
- Engaging with Districts to roll out HiAP across the County.
    - Due to capacity, the roll out plan is to support one organisation at a time. We are working closely with North West Leicestershire to embed the Leicestershire County Council HiAP model into their organisation and supporting their team to do this through a Train the Trainer model.

Healthy work, workplaces and gaining meaningful employment

<u>Healthy Workplaces Programme</u>

The Healthy Workplaces Leicestershire programme helps organisations of all sizes across the county to become healthier places to work. The tailored programme has been designed in collaboration with, and for Leicestershire business, helping to ensure that the support that is most needed by the county's workforce is available to them and their organisation.

The data below indicates businesses that are currently engaged with the Healthy Workplaces Programme:

- 125 registered organisations across both Leicestershire and Rutland (73 Large, 28 Medium and 24 Small organisations). The programme works with companies from both the public and private sectors, spanning a wide range of industries such as education, hospitality, finance and construction, to name but a few.
    - District progress towards accreditations - Harborough close to committed, Melton achieved committed, NWLDC close to achieving committed & Charnwood working towards empowered.
- 106 of new businesses enquired
- 42 Workplace Health Needs Assessment carried out

- 23 companies purchased products from HWP.

Work Well Programme

- The LLR Work Well Programme has been devised to support the ICS vision of 'working together for everyone in LLR to have healthy, fulfilling lives.' It is a support service that addresses the rising flow of people out of work. It has been launched by the Department for Work and Pensions (DWP) and the Department of Health and Social Care (DHSC) and aims nationally to support around 60k long-term sick and disabled people to start, stay and success in work through integrated work & health support. The LLR programme is one of 5 national Vanguards established to provide this service.
- In Leicestershire 15 PCNs have gone live in March 2025 with recruitment of Work Health Coaches (WHCs) and Seniors and Coaches underway.
- The LLR training hub has been commissioned to deliver work & health coach training and development, supervision & competency aligned to the personalised care framework and NHSE Care Navigation Competency Framework. There is collaboration with LCC and Adult Education Centre to build a skills and training package of core skills (functional, digital and personal).

Active Together – Healthy Workplaces

- In collaboration with local physical activity sector employers and CIMSPA, Active Together launched with the Local Physical Activity Sector Skills Plan 2024-2027 with recommendations and actions aligned to improving the conditions for, and ability of, the local sector to recruit, train, support and retain a representative, inclusive and skilled physical activity workforce while supporting the physical health and wellbeing of the people of Leicester, Leicestershire, and Rutland. The plan includes actions to ensure a greater need for health-based learning and development embedded within establish physical activity sector training.
- Initial conversations with the Work Well programme team to consider how we can upskill the health and work coaches around physical activity to support signposting into physical activity services.
- Working in partnership with The Youth Sport Trust, Active Together, has led Generation Charnwood – a government-funded project to use sport to improve the wellbeing, life chances, and employability skills of young people in Charnwood.

Healthy Housing and homeless prevention

Health Impact Assessments (HIA)

- Worked closely with districts to ensure health and wellbeing is enhanced through Local Plans. This has included drafting policies, embedding HIA requirements on new developments going forward and appraising Local Plan policies against a health impact assessment.

- A local HIA template and guidance has been developed by Leicestershire County Council Public Health team. The level of information required in the HIA will be proportionate to the scale and nature of the development proposed.

Statutory Homeless Duties

- Districts continue to deliver their statutory homelessness duties, including prevention of homelessness.
- Rough Sleeper Initiative and Rough Sleeping Accommodation Programme continues across all seven districts.
- Link between homelessness and the Safeguarding Adults Board (LSAB) has been strengthened, in line with a ministerial requirement. Designated senior leads in place for the safeguarding board on homelessness.
- Rough sleeping initiative project, caseload position, rough sleeper mortality project outcomes and prevention opportunities across LLR reported to LSAB in Jan and March 2025, and will be included within the refreshed strategic plan. Important opportunity to ensure homelessness is seen as more than a housing issue, management of all partners is key.

Social Housing Regulation Act

- The Social Housing (Regulation) Act 2023 came into force in April 2024. All district council landlords and registered housing providers (RP's) with 1000+ homes are subject to the associated requirements and must adhere to a set of standards known as consumer standards, which are monitored and reported on by way of inspection which will take place every 4 years. So far, one council has had their routine inspection – Melton Borough Council, and has received a compliant C2 judgement. Critically, the inspection showed that homes are safe, and tenants are supported. Improvement areas are being managed in a planned way.

Resilient, independent and supported older people

Public Health

- Public Health have continued to embed health considerations within Local Plans, covering health data, template policies and health impact assessment support both strategically and through policy to be applied to planning applications. A key focus on ageing populations and urban design considerations for elderly as well as accessibility needs have been included in all Local Plan work. Awaiting final consultation/examination across the County.

Local Transport Plan

- Local Transport Plan 4 phase 1 is complete with health as a core theme of the work moving forward. The work has a particular focus on the travel needs of the older population and the importance of inclusive travel modes.

Transport Improvements

- The partnership supports initiatives that promote the independence of the aging population including transport improvements such as:
    - FoxConnect improvements, as it's created positivity in terms of connectivity for our rural communities
    - There is a specific project across Melton and Rutland (Dynamic Demand Response Transport (DRT)) which has recently introduced Call Connect.

Supporting community cohesion

Sports and Violence Reduction

- Continue the partnership between Active Together, Street Games and Leicestershire Violence Reduction Unit to use local sport and physical activity assets to desist young people from engaging in violent crime and antisocial behaviour.

Air Quality and Health

Air Quality Needs Assessments

- Air Quality Health Needs Assessment completed, and recommendations embedded in action plan. Partnership formally adopted action plan in January 2025.

Explore a new approach to the design of our residential, employment and town centre environments

- The partnership has recently supported work to advance within the health and strategic planning system, and this will remain a key focus moving forward.
- Local Transport Plan 4 phase 1 is complete with health as a core theme of the work moving forward. The work has a particular focus on the sustainable active travel.

Reducing fuel and food poverty (cost of living crisis)

Food Insecurity

- Exercise underway to map food provision across Leicestershire, including food banks, community fridges, and food pantries.

- Food insecurity working group established with partners from across the county including reps from each district; with aim of sharing best practice / learning.

Housing and Respiratory Illness Project

One year since implementation, the programme has achieved significant progress:

- *Stronger Healthcare-Housing Partnerships*: The East Midlands Ambulance Service is now a key reporting partner, helping to identify and flag cases of damp and mould during emergency callouts.
- *Increased Housing Referrals*: Family help hubs and local healthcare services have fully integrated the housing referral system, increasing early interventions and preventative action.
- *Data-Driven Targeting*: A damp and mould mapping tool is in development, using data from housing associations and local authorities to identify high-risk areas and prioritise interventions.
- *Improved Health Outcomes*: Follow-up assessments on completed cases indicate reductions in medication use, fewer respiratory-related GP visits, and overall improvements in residents' health and wellbeing.

Warm Homes: Social Housing & Social Housing Fund

- Circa £10 million of funding secured (North West Leicestershire DC, Hinckley and Bosworth Borough Council and Melton Borough Council to carry our improvements to energy efficiency of council housing stock).
- A number of Leicestershire District Councils have recently secured funding from the recent wave of the Warm Homes: Social Housing Fund which will directly address affordable warmth and seeks to upgrade social housing stock to EPC level C as a minimum. Includes insulation, solar panels, lighting, windows and doors. Link here: Warm Homes: Social Housing Fund Wave 3 – successful Social Housing Landlords including local authorities and housing associations - GOV.UK. LLR allocations in March 2025 include:
    - Hinckley & Bosworth Borough Council £1,150,253
    - North West Leicestershire District Council £8,069,584
    - Allocation as part of Midlands Zero Net Hub (£75m) –Leicester City Council, Melton Borough Council
- In response to concerns about low take up of Pension Credit, District Council partners have supported local communities by raising awareness of the support available via this, and the Age UK Leicestershire Warm and Wise Scheme.
- Warm Homes has successfully delivered Home Upgrade Grant phase 2 (HUG2) funding provided by the Department for Energy Security and Net Zero and is anticipated to deliver approximately 160 energy efficiency measures across 120 households.
- Implementation of county wide Flexible Eligibility mechanism to widen access to national Energy Company Obligation (ECO) funding providing energy efficiency upgrades to low income and health poor households.

- Delivery of HERO demonstrator project funded by Midlands Net Zero Hub (Home Energy Retrofit Offer) providing tailored advice through 1-2-1 home visits, free Energy Performance Certificate assessments and public events. 482 households have been supported to date. The project is on target to meet over 80% of the KPI target for 1-2-1 advice.
- Revised Warm Homes advice booklet resource.
- Leicestershire performs better than the regional average and national average for percentage of households experiencing fuel poverty (12.5% vs 15.1% vs 13.1%). Based on DESNZ 2022 statistics. Fuel poverty proportionally has increased across all metrics driven by higher average and increasing energy prices when compared with those prior to the Covid-19 pandemic and a spike at the onset of the conflict in Ukraine. The most recent data for 2024 only details the regional and national statistics showing a reduction to 10.9% and 11% respectively driven by lower energy prices.
- The Rural Food Hub Network, funded by UKSPF, aims to support residents living in rural areas of Melton Mowbray with emergency food and other essential items The Rural Food Hub Network was developed as part of the council's cost of living offer to the Melton community. A number of hubs have been launched since February 2024, through the support of Government funding and provide vital support to residents in need, alongside other initiatives to support our communities such as the Household Support Fund and Pension Credit awareness events. New Food Hub launches in Asfordby – Melton Borough Council

Review impacts of climate change (including embedding national sustainable food places framework)

<u>Sustainable Food Places</u>

- Leicestershire has successfully achieved the Silver Sustainable Food Place, the first two tier county area to do so. We are now progressing for Gold.
- This work will now sit with the developing Whole System's Approach to Healthy Weight, Food and Nutrition programme, and will be focussing on areas including procurement practices, access to healthy and sustainable food and food insecurity.

JLHWS Priority 2: Enabling healthy choices and environments

Making Every Contact Count

MECC

- Healthy Conversation Skills webinar has been developed and delivered to LLR PCNS during protected learning time.
- Estates and Facilities staff within UHL trained up as trainers to deliver HCS training.
- Focus group with trainers completed to understand impact of the training on their roles.
- HCS training embedded as a product within Healthy Workplaces
- Conversations have started on embedding HCS training within ASC in LCC. Continued to deliver quarterly open learning and development session to LCC staff.

Enabling Healthy Choices (Comms & Awareness)

District and Partners Communication & Engagement

- Countywide partnership – LCC, Districts, with Active Together remains positive.
- Leisure contracts / facilities secured in Leicestershire in 24/25, notably Melton and Harborough with 10 year contracts agreed. Added value from the contracts, including specific interventions to address areas of health inequality (example – 'Melton Mowbray West') – a direct outcome of the Community, Health and Wellbeing Partnership.
- Locally Relevant and Targeted: Case Study – Farmer's Health Checks, Melton Mowbray Livestock Market. Funded by the UK Shared Prosperity Fund as a key intervention through the Melton Borough Council UKSPF plan, this is a great example of a relevant service which is helping to bridge the gap for farmers, who may otherwise not have time or choose not to prioritise their health / checks. Up to the end of November 2024, 1298 physical and mental health checks had been carried out for over 1290 farmers (I have asked for the updated figures). It is delivered by a charity, LRSN, who also operate across Lincolnshire. This has been cited as a best practice project in national publications. It has recently been agreed to continue to fund the project for a further 12 months.
- Melton BC: Physical Activity Pathway & Farmers Health Checks
- Charnwood: Secured funding for subsidised leisure centre passes and have installed exercise equipment and engaged an instructor on our most deprived estate through a Loughborough University Active Healthy Living study. Two 'healthy relationship' groups supported by UWAVA (one for males and one for females) at one our community hubs

- Hinckley & Bosworth: Regular health prevention updates are included in the Council's free newsletter that is distributed to 47,500 households 4 times per year.
- NWLDC: continued to deliver new programmes ESCAPE Pain and Active Menopause in addition to Steady Steps etc.
- Blaby: received 1,235 referrals into the service, with over 16,000 attendances in our programmes and 1132 participants across 42 activities.

HWB Partners Comms & Engagement

- The Health and Wellbeing Board microsite was developed: https://www.leicestershire.gov.uk/health-and-wellbeing/leicestershire-health-and-wellbeing-board
- The website signposts to health and wellbeing support services across Leicestershire: https://www.leicestershire.gov.uk/health-and-wellbeing/leicestershire-health-and-wellbeing-board/health-and-wellbeing-support
- Supported with the design of the HWBB annual report: https://www.leicestershire.gov.uk/about-the-council/how-the-council-works/other-bodies/about-the-health-and-wellbeing-board and a video overview.
- Leicestershire Health and Wellbeing Board X account: https://x.com/leicshwb continued to share and post messages to support residents to follow healthy lifestyles.
- Some of the key campaigns LCC promoted are stop smoking, weight management, Warm Homes, Healthy Workplaces, vaccinations, Family Hubs, Best Start in Life (first 1001 critical days), carers support, mental health (Start a Conversation , Mental Health Friendly Places and Mental Health Friendly Clubs).
    - Quit Ready stop smoking service – promoted messages across the year to encourage smokers to quit smoking using a range of communications tools including social media, digital advertising, articles in Leicestershire Matters (residents publication delivered to all households in Leicestershire), press releases and internally to council staff.
    - Promoted healthy lifestyle messages linked to national campaigns including Stoptober, Time 2 Talk day, mental health awareness week.

Active Together & Partners Comms & Engagement

- 3832 responses received as part of the LLR Physical Activity and Wellbeing Residents Survey. The aim of the survey was to understand the attitudes, behaviours and intentions of our local residents to support service delivery and messaging to get more residents to take part in regular physical activity.
- 18.9% of Leicestershire adult residents are inactive, with us performing better than England average (22.6%).
- 70.1% of Leicestershire adult residents are active, with us performing better than England average (67.1%).
- 45.1% of Leicestershire child residents are physically active, with us performing slightly below the England average (47.8%).

- Over 75 Let's Get Moving Champions have shared their inspirational stories on what being active means to them
- Place(s) Led Physical Activity Plans in place across the 7 districts and boroughs, with a physical activity delivery model focusing on:
    - people with specific health needs;
    - programmes aimed at inactive people with one or more stable health conditions;
    - programmes aimed at providing population-level interventions with brief advice and sign posting for self-help.

Healthy Weight Strategy

Whole Systems Approach to Healthy Weight, Food & Nutrition

- Through the development of the Whole Systems Approach for Healthy Weight, Food and Nutrition, the Healthy Weight Strategy and Food Plan are proposed to be amalgamated and form part of the governance structure for the WSA. Wider determinants also feature strongly through both previous work streams and will feature heavily in the WSA.
- An internal Food Systems workshop was held in Feb 25 to bring LCC senior leaders on the journey with a wider stakeholder workshop planned for May which will bring together a broad range of partners to map the local system and ensure that partners are working towards the same vision.

Physical Activity Elements of Weight Management

- Active Together and the district / borough councils and School Sport and Physical Activity Partnerships continue to support the physical activity elements of the Leicestershire Weight Management Service when required.

Sexual Health

Local Sexual Health Services

- Local sexual health services have been redesigned to improve accessibility of services for residents following a public consultation exercise that revealed a preference towards county-based provision. This now includes a standalone online SH service, a new service for county and Rutland residents from 01st April 2025, a review and re-procurement of the Long-Acting Reversible Contraception (LARC) offer.
- Leicestershire now performs in line with the regional averages and slightly better than the national average for chlamydia screening in females aged 15 to 24 (Leics 20.9% vs regional 22.7% England 20.4%).
- Leicestershire performs better than the regional average but significantly worse than the national average for HIV testing

- Leicestershire has consistently performed better than the regional and national averages for abortion rate in the over 25s (14.6/1,000 vs 16.1/1,000 vs 17.9/1,000)

Building healthy environments, fast food outlets alcohol premise density

Fast Food Outlets

- Local Planning authorities (districts) are being supported to build an evidence base and policy wording for hot food takeaway policies within Local Plans. Pilot of Public Health responses on hot food takeaway applications in Blaby has commenced. Work across Public Health to reduce density of fast food/gambling establishments and licensed premises in areas of health inequalities.

Progress against cross-cutting priorities of the JHWS

JLHWS Cross-cutting priorities:

- **Reducing health inequalities**

Learning Disability Health Checks

- National performance data from NHSE indicates that LLR has exceeded the Q1-3 AHC targets within our Operational Plan – more AHCs are now being completed earlier in the financial year
- Current local data indicates that 78.6% of people on the LD Register, aged 14+, have received their AHC during 24/25. The 75% target has been achieved ahead of last year's position, indicating that over 80% of people will have received their AHC by the end of 24/25
- The number of people added to the LD Register in LLR has continued to increase year on year – annual validation of individual practice registers carried out by the Primary Care Liaison Nurses
- System wide LD AHC Project Group established, led by LD Clinical Lead
- GP Ambassador Network established by PCLNs, including monthly informal drop-in sessions for GPs and Practice Nurses
- LD Friendly GP Practice Awards launched across LLR to raise awareness and improve access for AHCs
- QI project launched to improve uptake of AHCs for 14–19-year-olds, creating links with EHCP process
- LLR participating in a national NHSE pilot to examine feasibility of combining existing health checks for LD, Autism and Severe Mental Illness.

Temporary Accommodation Welcome Packs

- Temporary accommodation resources have been developed by both HBBC and MBC and will be shared with CHOG reps should partners wish to adopt and localise either resource.

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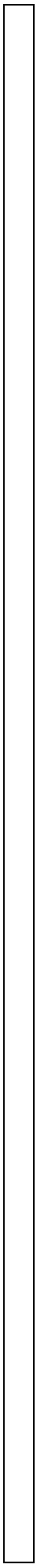
Women's Health

A Health Needs Assessment is process of being finalised; to help inform the partnership plan, it will also inform a prioritisation review for the partnership too:

- Women's Health Hubs have been established and are running well. There are three hubs across LLR, with one based in Northwest Leicestershire, one covering Rutland and Melton and a final one within the City.
- An East Midlands Fertility Policy is in development. A fertility project group is in place which has undertaken a review of internal processes and is getting ready for when the new policy is finalised.
- A group covering Termination of Pregnancy has been established to improve TOPs services. New commissioning guidance has just dropped from national, more work needs to be done from these recommendations on quality and performance measures within the network but on the whole, LLR are performing well against the new guidance. A mapping exercise is also underway and will be reviewed in summer.
- Development of an action plan covering gynaecology.

Progress against recommendations agreed at the Staying Healthy Partnership Development Session

JHWS Recommended Priorities (CFP Development Session)
Agreed to spotlight the following priority areas. These focus areas are alongside the SHPs existing remit to monitor ('watch') and champion activity across a range of delivery areas: • ***Health and the Strategic Planning System*** – build on and enhance the existing collaborative work to increase awareness, and consideration of health implications and requirements within planning policy and decision making. • ***Healthy Weight*** – to come together and champion a whole systems approach and joint agenda and the co-ordination of resources towards healthy weight, food and nutrition.



Key Challenges

12. The challenges identified within each initiative will be addressed through the appropriate governance channels and, where necessary, through the Staying Healthy Partnership (SHP). Should any of these issues require escalation to the Health and Wellbeing Board (HWB), they will be brought forward in a subsequent report.

Next Steps

13. The following section describes where further focus will be placed over the next 12 months:

    a. Keep the momentum going on the great work currently taking place across the partnership as outlined in the tables above.

    b. Place greater focus over the next 12 months on the areas where Leicestershire faces ongoing challenges.

    c. Build on the work that has commenced in relation to health & the strategic planning system and Healthy weight.

    d. Complete a review of JLHWS commitments for Staying Healthy, Safe & Well strategic priority.

Background Papers

Report to Health and Wellbeing Board 23 May 2024;

https://democracy.leics.gov.uk/documents/s182800/SHP%20JHWS%20Progress%20Update_23May24_v9%20FINAL.pdf

Joint Health and Wellbeing Strategy 2022-2032

https://www.leicestershire.gov.uk/health-and-wellbeing/leicestershire-health-and-wellbeing-board/joint-health-and-wellbeing-strategy

Appendices

None

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Relevant Impact Assessments

Risk Assessment

14. Risk log managed as part of Staying Healthy Partnership governance.